NEWFANE CENTRAL SCHOOL DISTRICT

6048 Godfrey Road, Burt, NY 14028
Phone 716.778.6351 / Fax 716.778.6868
cschultz@newfanecentralschools.org

Welcome to the Newfane Central School District. In order to efficiently process your registration, please come prepared with the following documentation:

- Identity Proof
  - Driver's license or other official picture identification of parent or legal guardian
- Relationship Proof
  - Birth certificate, Baptismal Certificate or Guardianship papers
  - DSS-2999 form From Social Services (if appropriate)
- Proof of Legal Residence
  - A legal residence is where a parent/guardian is registered to vote and where they reside for the majority of the year.
  - Acceptable forms of proof are: tax bill, bank statement, voter registration card, cable bill, utility bill in your name with current address or a signed rent/mortgage agreement.
- Passport (for exchange students)
- All students need to provide immunization records and a physical form

After successful registration, the school will contact you with a start date. Please find below contact information that will be helpful as your child begins school in Newane Central School District.

Pre-K Newfane Early Childhood Center 6048 Godfrey Road Burt, NY 14028 716-778-6351 Principal: Mr. Peter Young	Grades K-4 Newfane Elementary School 2909 Transit Road Newfane, NY 14108 716-778-6376 Principal: Mrs. Danielle Hawkins	Grades 5-8 Newfane Middle School 2700 Transit Road Newfane, NY 14108 716-778-6465 Principal: Mr. Keith Crombie

Grades 9-12 Newfane High School One Panther Drive Newfane, NY 14108 716-778-6564 Principal: Mr. Daniel Bedette	Ridge Road Express Bus Transportation 716-778-8333	Central Registration 6048 Godfrey Road Burt, NY 14028 716-778-6351 Fax 716-778-6868

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐Male ☐Female Date of Birth: _____/_____/_____ (Month Day Year) Grade: _____ (preschool-12) ID#: _____ (optional)

Address: _____ Phone: _____

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

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

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

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth) **Signature** of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

If **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

FAMILY REGISTRATION FORM – NEWFANE CENTRAL SCHOOL DISTRICT

INFORMATION ABOUT ENROLLED STUDENTS

STUDENT (1)	STUDENT (2)	STUDENT (3)
Legal Name:	Legal Name:	Legal Name:
Birthdate:	Birthdate:	Birthdate:
Last Grade Completed:	Last Grade Completed:	Last Grade Completed:
Current Grade:	Current Grade:	Current Grade:
Gender:	Gender:	Gender:
Ethnicity:	Ethnicity:	Ethnicity:
Relationship to Parent/Guardian:	Relationship to Parent/Guardian:	Relationship to Parent/Guardian:
Name of previous district:	Name of previous district:	Name of previous district:
Name of previous school:	Name of previous school:	Name of previous school:
IEP or 504 Plan (circle)	IEP or 504 Plan (circle)	IEP or 504 Plan (circle)
Any educational considerations/services: **OT PT Speech Small Class AIS _____**	Any educational considerations/services: **OT PT Speech Small Class AIS _____**	Any educational considerations/services: **OT PT Speech Small Class AIS _____**
Allergies/Serious health concerns?	Allergies/Serious health concerns?	Allergies/Serious health concerns?
Special Guardianship or Custody Issues?	Special Guardianship or Custody Issues?	Special Guardianship or Custody Issues?

INFORMATION ON PARENTS/PRIMARY LEGAL GUARDIAN(S)

FATHER	MOTHER	OTHER - Specify
Name:	Name:	Name:
Address:	Address:	Address:
Is above address the primary residence of the enrolled student(s)? **Yes or No**	Is above address the primary residence of the enrolled student(s)? **Yes or No**	Is above address the primary residence of the enrolled student(s)? **Yes or No**
Employer:	Employer:	Employer:
Occupation:	Occupation:	Occupation:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email:	Email:	Email:
Ethnicity:	Ethnicity:	Ethnicity:

INFORMATION ON OTHER CHILDREN OR ADULTS RESIDING IN THE HOUSEHOLD

Name	Age (DOB)	Relationship in/to Family

EMERGENCY CONTACTS

Please list all individuals who can be called in an emergency and/or are permitted to pick up your children from school.

Name:	Name:	Name:
Address:	Address:	Address:
Relationship:	Relationship:	Relationship:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email:	Email:	Email:
Call in an emergency? **Yes or No**	Call in an emergency? **Yes or No**	Call in an emergency? **Yes or No**
Can pick-up from school? **Yes or No**	Can pick-up from school? **Yes or No**	Can pick-up from school? **Yes or No**
Name:	Name:	Name:
Address:	Address:	Address:
Relationship:	Relationship:	Relationship:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email:	Email:	Email:
Call in an emergency? **Yes or No**	Call in an emergency? **Yes or No**	Call in an emergency? **Yes or No**
Can pick-up from school? **Yes or No**	Can pick-up from school? **Yes or No**	Can pick-up from school? **Yes or No**

Certification: I herby certify that I am a legal resident of the Newfane Central School District and that the above information is both accurate and complete to the best of my knowledge.

Parent/Guardian Signature: _____ 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.

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

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
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:

Kindergarten Questionnaire

Student Name:_____ Grade: ____

QUESTION	ANSWER
What do you wish your child to be called?	
EDUCATIONAL INFORMATION	
Is your child attentive when you read to them?	Yes No
Does your child read?	Yes No
Has your child had experience using scissors?	Yes No
Has your child had experience using glue/paste?	Yes No
Does your child speak in sentences?	Yes No
Does your child follow most instructions?	Yes No
Do you have difficulty understanding your child? In what way?	Yes No
Do others have difficulty understanding your child?	Yes No
Did your child attend nursery school, preschool, or daycare?	Yes No Name of nursery school(s), preschool(s) or daycare(s)
SOCIAL/EMOTIONAL INFORMATION	
Has your child had an opportunity to play with children outside the family?	Yes No
Is your child comfortable in social situations with children his/her own age?	Yes No
How does your child solve a disagreement with another child?	
What are your child's main interests?	
Is your child involved in outside activities? What activities are they involved?	Yes No
Has your child expressed any concerns about coming to school?	Yes No
How does your child react to new situations?	
Does your child have any fears?	
What causes your child to cry?	
Does your child "temper tantrum", if so, generally what are the circumstances? How frequently?	Yes No
OTHER	
Does your child dress him/herself? Please circle what they **can** do.	Yes No Button Zip Snap Tie Shoes
How often have you moved in the past 5 years? Has this been a problem for your child?	
Does the work of either parent require that they be away from the home for extended periods? How often?	
If both parents work, who will care for the child before and after school?	

******If there are any situations in the home or information you think may be helpful for us to know and understand your child please use the back to provide us with this information.**

GOOGLE APPS FOR EDUCATION

Newfane Central School District requires consent from a parent before offering the tools of Google Apps for Education including Gmail, G-drive, Google docs, Google sheets, Google calendar and other Google tools. Using Google G-Suite, students can collaboratively create, edit, and share files and websites for school related projects and communicate electronically with other students and teachers. These services are online and available twenty-four hours a day, seven days a week from any Internet connected computer. Newfane Central School District use of Google G-Suite is set up and secured for educational purposes. For that reason, students are not subjected to advertising as it is disabled when students access Google G-Suite.

☐ I give my consent ☐ I do not give my consent

USE OF VIDEOCONFERENCE PLATFORMS FOR REMOTE INSTRUCTION

Student use of videoconferencing or school property for classwork constitutes assent by the parent and student that no person, other than a teacher or other authorized district or school staff, will: record audio- or video conferences among students and/or teachers; nor will any person other than a teacher or other authorized district or school staff post any portion on the internet; nor store or share recordings digitally or in any other form.

☐ I give my consent ☐ I do not give my consent

PUBLICITY (NOT LIMITED TO TELEVISION, NEWSPAPER, WEBSITE, SOCIAL MEDIA)

NCSD encourages promotion of outstanding student achievement and recognition of school related activities. With your consent, we will allow for the recognition of your child in District related print and online publications and promotions which may include a student's full name, school and grade level, photographs, video, audio, examples of work, recognition for achievements and/or involvement.

☐ I give my consent ☐ I do not give my consent

STUDENT ACCEPTABLE USE PROCEDURES

I have read and agree to abide by the Acceptable Use Procedures (AUP) and guidelines of the Newfane Central School District. Further, I have discussed the important points contained with my child(ren). I understand that violations of the student AUP may result in suspension of Internet privileges and disciplinary actions.

PLEASE HAVE YOUR CHILD RETURN THIS SIGNED FORM TO THE MAIN OFFICE

Print name of student _____ Grade Level_____

Signature of student _____ Date _____

Signature of parent _____ Date _____

Revised 07/2020

Newfane Central School District

6273 Charlotteville Road
Newfane, NY 14108
716.778.6888

Parents, Guardians & Students,

Welcome to Newfane Central School District. With any endeavor, we want to take steps forward with our parents as partners as it is the best way for children to grow. Please take a moment to read the acknowledgements below and, if agreeable, please check the consent boxes, sign, and return to the school. If you have any questions, please contact the building principal.

Acceptable Use Procedures (AUP) Acknowledgement

The Newfane Central School (NCSD) district recognizes that effective use of technology is important to our students and will be an essential part of their lives as adults. The District's computer system consists of various computer networks, hardware and software programs. This may include, but may not be limited to the linkage to the "world wide web" and/or the "Internet". When students use the technology provided by the district, they are to use it for educational purposes only according to district policy #7360 (complete policy is accessible on the Newfane Central School District website and at any of our main offices).

It is important for our students to remember that information stored on our network will not be considered private. During school hours, students will be guided in their usage of computer technology with instructional supervision. If any rules and regulations of district policy are broken, students may be subject to disciplinary action from building administrators, teachers and professional support staff. Furthermore, any interference with the policy may be subject to federal, state and local laws. Some of the following examples of "unacceptable use" are contained in the document below. These guidelines are to be reviewed and signed by our students and parent/guardian in accordance with district policy.

1) Usage of the district technology resources to download, send via email, print, display images and/or gain access to any obscene, pornographic and/or social networking websites.

2) Use of vulgar and obscene language which may be insulting, bullying or attacking to others. Also, it is to be noted that any assistance offered to a student participating in any above actions is also unacceptable.

3) Damaging, disabling, or otherwise interfering with operation of computers, system operation and any hardware or software associated with the District network by physical or electronic means.

4) Violation of copyright law and downloading of additional software and sharing folders to the network without written consent of the network specialist.

5) Revealing personal information about yourself or about any other student such as date of birth, addresses, and telephone numbers, etc.

6) Transmission of material for political lobbying, product advertisement and any other commercial enterprise is not acceptable.

7) Trespassing on another student account and use of password is unacceptable as well.

Newfane Central School District
6273 Charlotteville Road
Newfane, NY 14108

RELEASE OF RECORDS

Name of Student: _____ **DOB:** _____

Please release information and records as indicated to the Newfane Central School District.

Official Transcript of Grades
NYS Intermediate Assessment Results
NYS Regents Scores
NYS RCT Scores
RTI Documentation
Science Lab Deficiencies/Investigations
Health and Immunization Record
Attendance Records
Psychological Reports
Student Schedule
Special Education/IEP Records
Other State/Regional Test score

I give my permission to release my child's records to the Newfane Central School District.

Parent/Guardian Signature: _____

Federal Law 99.31 – No parent signature is required for educational records sent to another educational agency.

Please fax or mail records to the below indicated school (circled).

Newfane Early Childhood Ctr. 6048 Godfrey Road Burt, NY 14028 716-778-6351 Fax: 716-778-6868 Principal: Mr. Peter Young	**Newfane Middle School** 2700 Transit Road Newfane, NY 14108 716-778-6461 Fax: 716-778-6465 Principal: Mr. Keith Crombie
Newfane Elementary School 2909 Transit Road Newfane, NY 14108 716-778-6376 Fax: 716-778-6377 Principal: Mrs. Danielle Hawkins	**Newfane High School** 1 Panther Drive Newfane, NY 14108 716-778-6564 Fax: 716-778-6565 Principal: Mr. Daniel Bedette
Newfane Special Education 6048 Godfrey Road Burt, NY 14028 716-778-6458 Fax: 716-778-6467 Director: Mrs. Jennifer Bower	

Newfane Central School District
Student Emergency Information

Child's Full Name: _____
Date of Birth: _____ Place of Birth (City, State): _____

Legal Guardian #1's Name: _____ Relationship: _____
Guardian's Address: _____ Home Phone: _____
Guardian's Employer: _____ Work Phone: _____
Cell Phone: _____ Nearest Phone (if no home phone): _____
Email: _____

Legal Guardian #2's Name: _____ Relationship: _____
Guardian's Address: _____ Home Phone: _____
Guardian's Employer: _____ Work Phone: _____
Cell Phone: _____ Nearest Phone (if no home phone): _____
Email: _____

If natural parent is not legal guardian, please complete next section:
Father's Name: _____ Any restrictions on release to this person? _____
Mother's Name: _____ Any restrictions on release to this person? _____
Are there any custody issues, restricted release situations of which we should be aware?
_____

Emergency Contacts (Adults to whom child may be released if legal guardian in not available)
Name #1: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____
Name #2: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____
Name #3: _____ Relationship: _____
Phone: Home: _____ Work: _____ Cell: _____

Child's Usual Source of Medical Care
Name: _____
Address: _____
_____
Phone: _____
Last seen: _____

Child's Usual Source of Dental Care
Name: _____
Address: _____
_____
Phone: _____
Last seen: _____

Specialists: _____
_____

Child's Health Insurance
Name of Insurance Plan: _____ ID# _____
Subscriber's Name (on insurance card): _____

Parent/Legal Guardian Consent and Agreement for Emergencies
As parent/legal guardian, I give consent to have my child receive first aid by school staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above receive health information and **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs.
Date: _____ Parent/Legal Guardian's Signature: _____

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Newfane Central School District
Sharing of Confidential Information

To ensure the safety and well being of your child while in our care, it is sometimes necessary to share your child's confidential health information with the staff that has direct care and responsibility for your child. We have found that most children in the younger age groups we service are not yet ready emotionally or physically to be responsible for identifying the need for and seeking appropriate medical interventions without adult guidance.

We attempt to provide child specific health care plans based on medical directions from your child's health care provider and developed with you, the parents, so that each child's individual needs are met at their level of need. We begin this process at registration with a review of your child's health care risks and needs. Further information may be requested from you and/or your child's healthcare provider to assist us in the development of your child's care plan. Please be assured that information shared is on a need to know basis, and is considered to be privileged and confidential by all of our staff. Staff may include, but is not limited to, the principal, teachers, instructional associates, school nurses, therapy providers, tutors, cafeteria staff, office staff, and bus drivers and aides and substitutes for all of these positions.

You have the right to restrict the information being shared with the staff that may have contact with your child during the school day as well as to restrict which staff may have access to this information. By signing below, you are giving us permission to share pertinent health information as needed to ensure that each staff person who has direct contact and responsibility for the care of your child is able to identify and appropriately respond to any special health care needs of your child. You have the right to rescind this consent at any time during the school year.

I, _____, give consent for the school nurse to consult with my child's healthcare providers to develop a plan of care for my child and for release of pertinent information from my child _____'s health history and health care plan with staff of the Newfane Central School District and Ridge Road Express who will have direct responsibility for the safety and care of my child, on a need to know basis as determined by the school nurse, or limited to the following staff:

_____

_____ _____

Parent's Signature/Date Parent's Signature/Date

Newfane Central School District
Developmental History

Pupil's Name _____ Sex _____ Birth Date _____
(Last) (First) (Middle)

Prenatal / Pregnancy: Mother's age _____ Length of pregnancy _____ weeks Prenatal Care _____

Adopted _____ At what age _____ Foster Care _____ At what age _____

Pre-existing maternal medical conditions, medications used during pregnancy (prescription, over the counter and recreational), accidents or injuries during pregnancy, lack of or late prenatal care. Problems: infections, bleeding, high blood pressure, anemia, gestational diabetes, fever, trauma, inherited disease, medication (other than iron, vitamins), chronic disease, hospitalization, swelling, other:

_____

_____

Labor and Delivery: Length of labor _____

Type of delivery: Vaginal _____ Cesarean _____ Forceps _____ Suction _____ Breech _____

Anesthesia / Medications: _____

Neonatal: Birth weight _____ Premature _____ Postmature _____

Problems at birth or shortly after (breathing, infection, jaundice, bleeding, transfusions, antibiotics, birth defects, feeding, self temperature regulation, oxygen needs, blue spells, seizures, other): _____

_____

Developmental: At what age did your child do the following: Sit alone _____ Roll over Unassisted_____

Stand alone _____Walk alone _____ Sleep through the night _____

Speech: Words:_____ Sentences: _____ Toilet trained: Urine _____ Stool _____

Toileting assistance needed? _____What type? _____Frequent accidents? Fecal _____ Urine ____

Diapers/Pull ups currently used? _____ When: _____

Feeding habits: Regular mealtimes? _____ Snacks? _____ Over or Underweight for age? _____

Special diet needed? _____ Experience using utensils? _____

Usual tv/computer/video game usage: _____ Usual amount of daily physical activity: _____

Usual physical activities: _____ Organized activities? _____

Difficulty with: Tying shoes _____ Using zipper _____ Using buttons _____ Dressing self _____

Using scissors _____ Holding pencil/crayons _____ Mobility concerns _____

Usual bedtime _____ Usual # of hours of sleep _____ Naps: _____ Sleeps through night _____

Development: faster, slower, or equal to brothers/sisters/peers _____ Dominant hand: _____

Has your child ever been evaluated (other than well check-ups) **for concerns** with his/her:

Speech: _____ Fine or Gross Motor Abilities: _____ Behavior: _____ Vision: _____ Hearing: _____

Recommendations: _____

_____

_____

Please check the information that applies and add any pertinent information:

Allergies (specify reaction and allergen):
- Foods _____
- Environmental/Seasonal: _____
- Insects: _____
- Medications: _____

Accidents:
a. Serious head injury _____
b. Loss of consciousness _____
c. Other (specify) _____

Eye Difficulties:
a. "Lazy eye" _____
b. Glasses or contact lenses _____
c. Prosthesis _____
d. Other (specify) _____

Ear/Nose/Throat Problems:
a. Frequent ear infections _____
   Age 0-2: _____ Current: _____
b. Tubes _____
c. Hearing loss _____
d. Throat infections _____
e. Enlarged tonsils or adenoids _____
f. Other (specify) _____

Heart Problems:
a. Heart murmur _____
b. Congenital heart disease _____
c. Rapid heartbeat/palpitations _____
d. Other (specify) _____

Respiratory Difficulties:
a. Asthma _____
   Triggers: _____
b. Bronchitis/pneumonia _____
c. Cystic fibrosis _____
d. Other (specify) _____

Kidney/Bladder/Bowel Difficulties:
a. Kidney disease _____
b. Bladder infections _____
c. Urinary reflux _____
d. Enueresis (bedwetting) _____
e. Chronic constipation _____
f. Encopresis (fecal soiling) _____
g. Undescended (or one) testicle(s) _____

Musculoskeletal/orthopedic problems:
a. Joint pain or swelling _____
b. Limitations of movement _____
c. Fractures _____
d. Braces/wheelchair/adaptive equipment _____
e. Prosthesis _____
f. Other (specify) _____

Poor Coordination (specify): _____
a. Fine or gross motor delays (specify) _____

Birth Defects (specify): _____

Hospitalizations / Operations (specify): _____
_____
_____
_____

Illness with high fever (> 103°F): _____
a. Seizures _____
b. Staring spells _____
c. Tics _____

Currently or regularly taken medication _____
_____
Reason _____
Is medication required in school? _____

Skin Conditions (specify): _____

Mononucleosis _____

Tuberculosis (TB) contact _____

Diabetes _____

Hepatitis _____

Thyroid disease _____

Gastric Reflux _____

Speech delay (specify): _____

Emotional problems (specify): _____

Attention problems (specify): _____

Elevated lead level: _____

Other (specify): _____
_____

Special Education Needs: _____

Does any close relative in your family have a history of: (Check and indicate relationship to this child.)

Diabetes _____ Cancer _____ High Blood Pressure _____ Birth Defect _____
Anemia _____ Epilepsy _____ Sickle Cell Anemia _____ Heart Disease _____
Learning Problems _____ Mental Retardation _____ Other _____

Have there been any changes or additions to the family in the past year? (health problems, changes in marital status/custody, changes in occupation, new brother or sister, etc.) Explain: _____
_____

Signature _____ Date: _____
Parent/Guardian

NEWFANE CENTRAL SCHOOL DISTRICT HEALTH HISTORY

(To be completed by parent/guardian)

Student Name _____ Sex _____ Date of Birth ___/___/_____
(Last, First, Middle Initial)

I. Life Threatening Allergic Conditions: (Check all that apply.)

[ ] Severe allergic reaction to Bee Stings, other insects: _____
[ ] Severe reaction to Nuts, Peanuts: _____
[ ] Severe reaction to other Food Products: _____
[ ] Other severe allergies affecting school: _____

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does *not* indicate a severe allergic reaction.)

[ ] Itching and/or tightness in the throat, hoarseness [ ] Itching or swelling of the eyes, lips, tongue or mouth [ ] Hives
[ ] Shortness of breath, coughing, and/or wheezing [ ] "Thready pulse", "passing out"/loss of consciousness

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy? [ ] Yes* [ ] No
Specify medication: _____
* If you answered "Yes", it is strongly advised that he/she have this medication at school. Carefully read the ***Medication Information*** below.

II. Health Conditions: Has your child been diagnosed with any of the following? Provide dates and details for all items checked "Yes".

Yes	No	Condition	Details/Dates
		Allergies to medications	
		Allergies (environmental or seasonal)	
		Anemia	
		Asthma/Reactive Airway Uses an inhaler? ___ Yes ___ No Uses a nebulizer? ___ Yes ___ No If your child uses an inhaler or a nebulizer, it is strongly advised that he/she have this medication at school. Carefully read the ***Medication Information*** below.	
		Attention deficit: ___ ADD or ___ ADHD Date diagnosed _____ Meds: ___ Yes ___ No	
		Autism/PDD: ___Autism or ___Aspergers or ___PDD-NOS (not otherwise specified)	
		Behavior problem	
		Bleeding disorder	
		Bowel or digestive problem	
		Cancer, Type: _____ Date diagnosed _____	
		Cerebral Palsy	
		Chromosomal disorder: ___ Down's syndrome ___ Other – specify →	
		Cleft lip/palate	
		Cystic Fibrosis	
		Dental problem	
		Depression	
		Developmental Delay (learning, motor, speech) If yes, does your child receive special services? ___ Yes ___ No	
		Diabetes: Date diagnosed _____ Insulin Dependent: ___ Yes ___ No	
		Eating disorder: Anorexia ___ Bulimia ___	
		Elevated lead level Date diagnosed _____ Last tested _____ Level _____	
		Emotional disorder	
		GERD Date diagnosed _____ Meds: ___ Yes ___ No	
		Growth problems	
		Heart problem: specify →	
		Head Injury Type:	
		Hepatitis, Type: _____ Date diagnosed _____	
		Hernia Type:	
		High blood pressure	
		Hospitalizations: specify →	
		Immunodeficiency disease	
		Kidney or urinary problem	
		Lyme Disease	
		Muscular disorder	

Yes	No	Condition	Details/Dates
		Migraine headaches	
		Nutritional/weight problem	
		Orthopedic problem (bone, joint)	
		Pregnancy	
		Rheumatoid Arthritis	
		Scoliosis/abnormal spinal curve: Date of diagnosis _____ Date of last evaluation	
		Seizure disorder, Type _____ Date of last seizure:_____ Meds: ___ Yes ___ No. Medication _____ (Please provide physician documentation of diagnosis.)	
		Self Harm/Mutilation	
		Sickle cell disease	
		Skin condition	
		Spina bifida	
		Substance abuse (alcohol, drugs, tobacco)	
		Suicide risk or attempt	
		Surgeries: specify →	
		Thyroid disorder	
		Tics or twitches	
		Tourette's syndrome	
		Tuberculosis	
		Other	
		My child is healthy and has no special health needs.	

Yes	No	HEARING
		Hearing loss: [ ] Right - ___Mild ___ Moderate ___Severe [ ] Left - ___Mild ___Moderate ___Severe Hearing loss due to _____ Last evaluation _____

Yes	No	VISION
		Color deficiency
		Legally blind
		Vision problem /Eye defect _____ Last eye exam _____
		Wears glasses [ ] All the time [ ] For distance only [ ] For reading only [ ] For sports
		Wears contact lenses

III. Medications: (Include all prescription, herbal and over-the-counter medication)

Name, dosage, route and frequency:	Used to Treat:

SCHOOL MEDICATION POLICY: If your child has a medical condition that requires medication in school, a written physician's order is required. No medication, including "over the counter" medications, may be carried by a student during regular school hours, at school-sponsored activities, such as field trips, *and* during after-school-hour activities. The only exceptions are for those students with asthma inhalers and Epi-Pens whose order specifies that they may "self administer" their medication and have been cleared by the school nurse. All medication must be delivered to the school Health Office by the parent/ guardian with the physician's original order and written parental permission. Medication order forms are available through the Health Office and on the District's website.

IV. Special Needs

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?
[ ] Yes* [ ] No Specify: _____

*** Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation before modifications can be considered.**

I understand that if my child's health status changes during the school year, I will provide the Health Office with updated information.
Parent/Guardian Signature _____ Date _____

NEWFANE CENTRAL SCHOOL DISTRICT

6273 Charlotteville Road
Newfane, NY 14108
716-778-6888

Re: Health Examinations

Certificate of Health for _____ Grade:_____

Dear Parent or Guardian:

Education Law requires all students enrolling in the Newfane Central School District and all students entering pre-K or K and in 1st, 3rd, 5th, 7th, 9th & 11th grades present a Certificate of Health, including BMI weight status, signed by a duly licensed physician. The school will provide a basic physical examination if a Certificate of Health is not received or an appointment with your personal physician has not been scheduled.

As the school's physical is limited to cardiovascular fitness and a general assessment of ears and throat, it is recommended that parents have their child examined annually by their family physician. If you choose to have your child/children examined by your own physician, please have your doctor complete the attached form and return it to me.

A law was recently enacted that expands health screenings to include the dental health of students in New York State. After September 1, 2008, when we require a physical examination, we will be *requesting* a dental certificate as well. There is a sample certificate attached that you may take to your child's dentist and once it is completed, it should be returned to the school nurse to be filed in your child's Cumulative Health Record.

Please let us know your plans by completing the information requested below. Return this letter to me by October 1st

Thank you for your cooperation in this matter. Our students benefit when we work together to promote the health and achievement of all students.

Sincerely,

Your School Nurse

NECC
Teresa Trank, R.N.
Phone: (716)778-6353
Fax: (716)778-6364

Newfane Elementary
Donna Winans, R.N.
Phone: (716)778-6374
Fax: (716)778-6363

Newfane Middle
Courtney Bedford, R.N.
Phone: (716)778-6470
Fax: (716)778-6462

Newfane High
Lisa Erck, R.N.
Phone: (716)778-6554
Fax: (716)778-6361

Our plan for providing the required certificate of health is to:

_____ Have our family physician examine our child.

_____ Certificate of Health is attached.

_____ Appointment is set for ___/___/___ with Dr. _____.

_____ Have the school physician examine our child.

_____ *Requested* dental appointment is set for ___/___/___ with Dr. _____.

_____ _____

Parent/Guardian Signature Date

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex assigned at birth: ☐ M ☐ F	DOB:
Affirmed name (if applicable):	Gender identity: ☐ M ☐ F ☐ Nonbinary ☐ X	
School: **NEWFANE** ☐ NECC ☐ ELEM. ☐ MIDDLE ☐ HIGH	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Food _____ ☐ Medication_____ ☐Insect ☐ Latex ☐ Environmental ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 Last HbA1c: _____ Date: _____ ☐Medication/Treatment Order Attached ☐ 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/m2 **Percentile (Weight Status):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns
(e.g. concussion, mental health, one functioning organ)

☐ Concussion history: Last occurrence_____
☐ Mental Health:
☐ One functioning: ☐ Kidney ☐ eye ☐ testicle
☐ Other:

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS – *required for PreK or K, 1, 3, 5, 7 & 11*

Vision ☐ With Correction	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/	☐ Yes ☐ No	☐
Color Perception Screening ☐ Pass ☐ Fail			☐ Yes ☐ No	☐
Notes				

Hearing 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.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No ☐
Notes			

Scoliosis screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐
	Degree of deviation:		Trunk rotation:	

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS List medications taken:

☐ **Order Form for Medication(s) Needed at School Attached**		

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS ☐ Immunizations given today:

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

NEWFANE CENTRAL SCHOOL DISTRICT

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 visit to a dentist? ☐ 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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

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

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

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

Dentist's name and address (please print or stamp)	Dentist's Signature

2023-24 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

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

NEW YORK STATE | Department of Health

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

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

For further information, contact:

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

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

Parents:

All kids entering **Grades 7-12** must have the **meningococcal vaccine.**

Without it, they can't start school.

About the Vaccine:

- It's not a new vaccine. It's been recommended for a decade.
- Most parents already choose to vaccinate their children.
- The meningococcal vaccine has been **required** for school entry since Sept. 1, 2016.

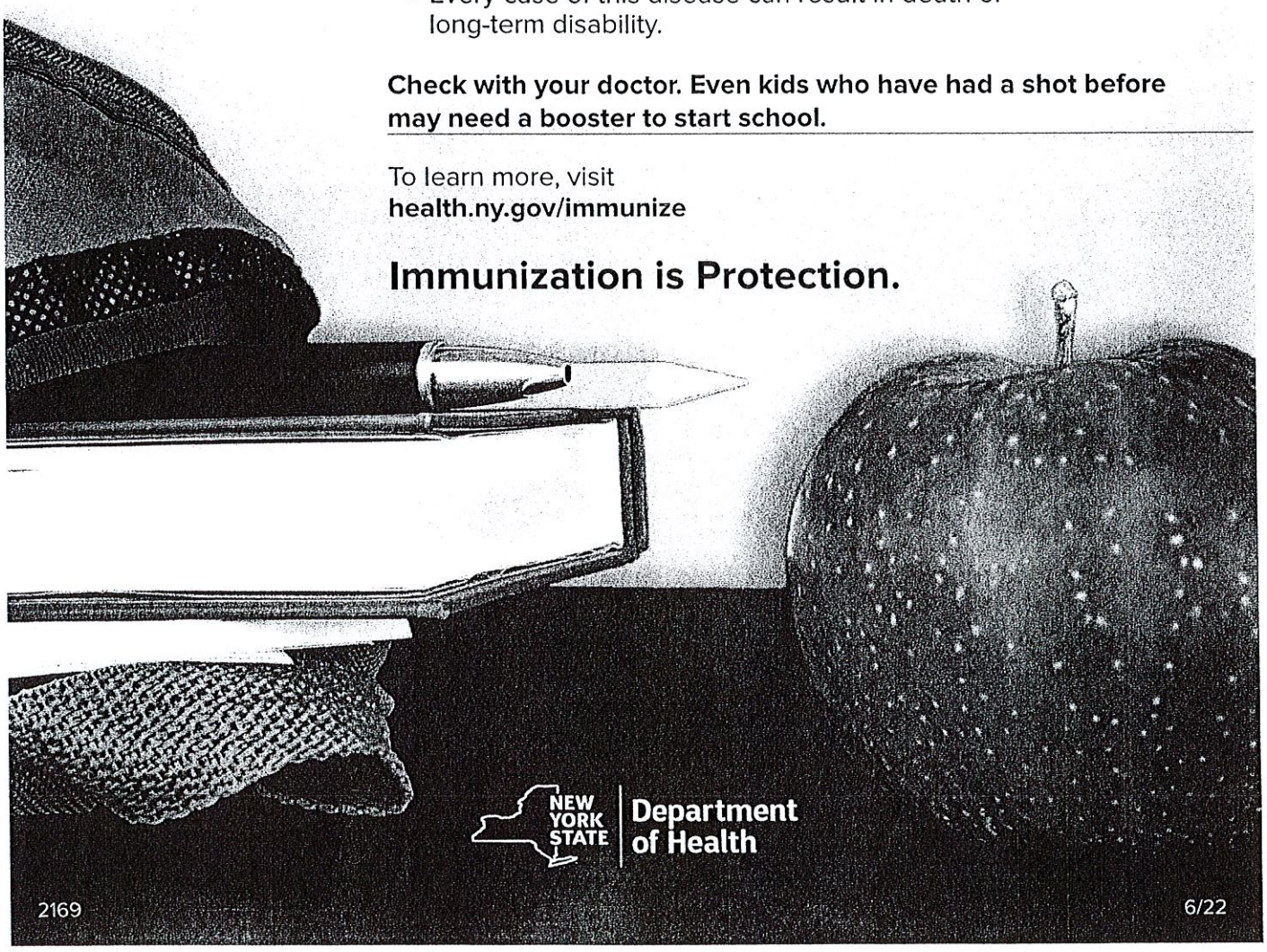
About Meningococcal Disease:

- It causes **bacterial meningitis** and other serious diseases.
- Teens and young adults are at greater risk.
- It comes on quickly and without warning.
- Its symptoms are similar to the flu.
- Every case of this disease can result in death or long-term disability.

Check with your doctor. Even kids who have had a shot before may need a booster to start school.

To learn more, visit
health.ny.gov/immunize

Immunization is Protection.



NEW YORK STATE | Department of Health

2169 6/22

Newfane Elementary School
Bus Schedule

Student Name: _____

Parent/Guardian Name: _____

Phone Number: _____

My child will be **picked up** at (name/address):

_____

_____

On _____ _____ _____ _____ _____ (check applicable days)
Mon Tues Wed Thurs Fri

My child will be **dropped off** at (name/address):

_____

_____

On _____ _____ _____ _____ _____ (check applicable days)
Mon Tues Wed Thurs Fri

My child will be dropped off at school by parent: ____ ____ ____ ____ ____ (check applicable days)
Mon Tues Wed Thurs Fri

My child will be picked up from school by parent: ____ ____ ____ ____ ____ (check applicable days)
Mon Tues Wed Thurs Fri

Additional Comments: