NEW STUDENT REGISTRATION PACKET

Please fill out all the forms in this packet and return it to the district office to register your child in our school.

Lyncourt Union Free School District

Lyncourt Union Free School District Registration

2707 Court Street
Syracuse, New York 13208
Phone 315-455-7571, Option 7; Fax 315-455-7573

Hours of Registration Office

8 AM to 11 AM
12 PM to 3 PM
} **During the School Year**

SUMMER OFFICE HOURS ARE
8 AM to 2 PM---PLEASE CALL FIRST

YOU MUST BE A RESIDENT OF THE LYNCOURT UNION FREE SCHOOL DISTRICT IN ORDER TO REGISTER AND ATTEND SCHOOL

The registration office is open each week Monday through Friday (excluding holidays) from 8:00AM to 11:00AM and 12:00PM to 3:00PM. Please call 315-455-7571 ext. 7 to schedule your appointment to come in.

In order to register your child for school in the district, you need to call and make an appointment AND you must be a resident of the Lyncourt Union Free School District. There are certain forms necessary to register your child for school and they can be downloaded from our website or you may come in person to pick them up.

When you come in to register your child, you will need to bring the following with you:

- **Proof of Residency** in the Lyncourt Union Free School District-acceptable proof of residency= **one** of the following with **a current date and your current Lyncourt address**:
  1) mortgage commitment paperwork,
  2) notarized lease/rental agreement for a home or apartment within the district,
  3) Pay stub,
  4) recent property tax or school tax bill
  5) information from the Department of Social Services (DSS) or Social Security (SSI), with **your** name, address , and current date on it
- Valid **birth certificate** with seal
- Updated record of **immunizations**
- Parent's photo identification

IF YOU ARE LIVING WITH ANOTHER FAMILY THAT RESIDES IN LYNCOURT, YOU MUST FILL OUT THE PARENT/ GUARDIAN AFFIDAVIT & SUBMIT A BANK STATEMENT, EMPLOYER LETTER, OR PAYSTUB THAT ESTABLISHES THE LYNCOURT ADDRESS AS THEIR ADDRESS. THE HOMEOWNER MUST COMPLETE THE RECEIVING PARTY AFFIDAVIT & SUBMIT A UTILITY BILL, LEASE AGREEMENT OR MORTGAGE PAPERWORK.

BOTH FORMS MUST BE NOTARIZED.

If applicable:

- Proof of guardianship (through court orders) or proof of custody.
- Parents/Guardians of special education students - child's most recent IEP (Individual Education Plan) and any other pertinent records. An additional form will need to be completed-available at our office
- Parents/Guardians with foster children must be accompanied by a social worker and paperwork should include Form DSS-2999 from the County Department of Social Services.

IF YOU ARE MISSING ANY OF THE REQUIRED FORMS FOR REGISTERING YOUR CHILD, YOU WILL HAVE FOURTEEN (14) DAYS TO SUBMIT THE DOCUMENT(S). PLEASE SUBMIT THE APPROPRIATE FORM(S) BY: _____. THANK YOU.

LYNCOURT UNION FREE SCHOOL DISTRICT STUDENT REGISTRATION

STUDENT'S NAME:_____ ☐ **MALE** ☐ **FEMALE** **GRADE**_____

ADDRESS:_____ **HOME PHONE #:** _____

DATE OF BIRTH: _____ **PLACE OF BIRTH:** _____

ETHNICITY: (Check one)

☐ American Indian/ Alaskan Native ☐ Black or African American ☐ Asian
☐ Hispanic/Latino ☐ White ☐ Native Hawaiian/Other Pacific Islander

CHILD RESIDES WITH: ☐ Father ☐ Mother ☐ Both Parents ☐ Other _____

CHILD'S PARENTS ARE: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

WHO HAS CUSTODY? ☐ Mother ☐ Father ☐ Mother & Father Jointly ☐ Foster Placement (DSS-2999 must be provided)
Copy of legal paperwork on file ☐ Yes or ☐ No Custody pending ☐ Yes or ☐ No

FAMILY STATUS (Living in household with student)

☐ *Father* ☐ *Step-Father* ☐ *Legal Guardian*

Name: _____
Address: _____
_____
Home Phone: _____ **Cell Ph.:** _____
Employer: _____
Work Phone: _____ **Pager:** _____
Email: _____

☐ *Mother* ☐ *Step-Mother* ☐ *Legal Guardian*

Name: _____
Address: _____
_____
Home Phone: _____ **Cell Ph.:** _____
Employer: _____
Work Phone: _____ **Pager:** _____
Email: _____

Additional Parent Information (Information regarding the parent not living with student.)

Relationship to Student: _____
Parent's Name: _____
Address: _____
Email: _____

Can they receive Report Cards and mailings from the district? ☐ Yes or ☐ No
Home Phone: _____ **Cell Ph.:** _____
Employer Name/Phone: _____

Note: District policy and legal requirements provide that both parents have equal access to their child(ren) and school records unless court papers are on file with the district.

SIBLINGS AND OTHERS RESIDING WITH STUDENT AT SAME ADDRESS

Name	Birth Date	Grade	Sex M/F	Relationship to Student
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

LYNCOURT UNION FREE SCHOOL DISTRICT STUDENT REGISTRATION (Page 2)

Student Name: _____

Is your child a U.S. Citizen? ☐ Yes ☐ No **Immigration date:** (if applicable) _____

Country of Origin: _____ **Date student entered school in the United States:** _____

What language is spoken at Home: _____ **What language does the student primarily speak?** _____

Did the student receive ESL (English as a Second Language) services from a prior school? ☐ Yes ☐ No

Has Student attended Lyncourt School before? ☐ Yes ☐ No If yes, please provide dates:

Is the student receiving Special Education services: ☐ Yes ☐ No

If yes, please check any services listed below that your child has received in the past school year.

☐ Resource Room ☐ Special Class Placement ☐ School Counseling ☐ Outside Counseling

☐ Occupational Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ Other

Is the student receiving any Academic Intervention Services (AIS) for any of the following areas, check all that apply:

☐ English ☐ Math ☐ Science ☐ Social Studies

Do you have any concerns about special needs for your child? ☐ Yes ☐ No If yes, please explain.

Has your student ever repeated a grade in school? ☐ Yes ☐ No If yes, what grade level(s)?

If this student is transferring from another school, please give the name and address of the former school.

LAST SCHOOL ATTENDED: _____ **GRADE:** _____

ADDRESS OF SCHOOL: _____ **FAX #** _____

_____ **PHONE #:** _____

Parent / Guardian Statement

Permission is hereby granted to the Lyncourt Union Free School District to obtain health and scholastic records from the above listed school as well as transfer records to a new school in the event of a move to another district or state.

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.

Signature of parent / guardian: _____ **Date:** _____

LYNCOURT UNION FREE SCHOOL DISTRICT
STUDENT REGISTRATION: RESIDENCY QUESTIONNAIRE

Student Name:

Please answer the following questions. This will help determine whether you are residents of the Lyncourt Union Free School District.

Is the current address and living arrangement in the Lyncourt Union Free School District the student's actual and only address/residence? ☐ **Yes** ☐ **No**

As the parent or legal guardian, is the place you claim as your residence, the place where you and your child sleep, reside, and use as a base of operation? ☐ **Yes** ☐ **No**

Does the student intend to remain permanently in the district? ☐ **Yes** ☐ **No**

Does the student live with the adult having physical custody (custodian parent or guardian) of the student? ☐ **Yes** ☐ **No**

I understand that:

- *If I provide false information on this registration form to the Lyncourt Union Free School District, I may be committing the crime of perjury in the third degree (a class A misdemeanor);*
- *If I provide false information on this registration form to the Lyncourt Union Free School District with the intent to defraud the Lyncourt Union Free School District, I may be committing the crime of perjury in the second degree (a class E felony); and*
- *I may be prosecuted on criminal charges for such false information.*

Signature of parent or guardian:_____

These questions are asked in accordance with the McKinney-Vento Act 42 U.S.C. 1134a [2] and Education Law 3209 (1)(a). The answers to the following residency questions will provide information to help the Lyncourt Union Free School District determine the services a student may be eligible to receive.

To be completed by a Lyncourt Union Free School District official.

Is the student in temporary living arrangements due to the loss of housing or economic hardship? ☐ **Yes** ☐ **No**

If the answer is YES, please complete the remainder of this form. If the answer is NO, you may stop here.

The student is currently living…

In a household with the custodial parent and/or legal guardian	**Yes**	**No**
In a shelter	**Yes**	**No**
With more than one family or relatives in a house or apartment	**Yes**	**No**
In a place not designed for ordinary sleeping accommodations such as a car, park, or transportation center/station (i.e. train, bus etc.)	**Yes**	**No**
In a motel, hotel, trailer park, camping ground or other similar situation due to the lack of alternative, adequate housing	**Yes**	**No**
In an abandoned apartment/building	**Yes**	**No**
In an Office of Children and Family Services (OCFS) facility awaiting permanent foster care placement	**Yes**	**No**
As a migratory child by moving from place to place	**Yes**	**No**
As an unaccompanied youth for whom no parent or person in parental relation is available	**Yes**	**No**

Temporary Address:

Please let us know your child's after school routine by indicating below: Your child(ren): _____

- Busser
- YMCA
- Walker that is picked up by a parent
- Walker that is allowed to walk home on their own or with a sibling
- Walker that is picked up by a babysitter or another family member. Please list babysitter or family member below:

  _____

  _____

  _____

  _____

Please remember that 2nd and 3rd grade parents need to report to the back lobby of the school, teachers and students will meet you there.

UPK, K, 1 parents will meet in the Main Entrance and proceed to auditorium, teachers will bring children to you.

4th & 5th graders will exit out of the front of the school or back, depending on if they are being picked up.

Thank you for your cooperation in this matter. Please sign and return this form to your child's teacher.

_____

Parent's Signature

LYNCOURT SCHOOL DISTRICT
Student Registration Form

Student _____ Grade: _____ StudentID _____

School: _____ Homeroom: _____

Date of Birth: _____ Student Home Phone: _____

Student Address: _____ Student Cell Phone: _____

_____

Mailing Address: _____ ☐ Please check if this address is temporary

_____

Contact Information:

The Schooltool Parent Portal provides parents and guardians access to assignments, grades and attendance information. To receive access, you must provide a valid email address and receive mail regarding the child.

Contact #1: Custody: Yes / No Student lives with: Yes / No
Relationship: Can Pick Up: Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

_____ _____

Phone Call Order

Employer: _____ Home Phone: _____ 1 2 3

Cell Phone: _____ 1 2 3

Email: _____ Work Phone: _____ 1 2 3

Please provide me with access to the Schooltool Parent Portal for my child? Yes / No

Contact in case of an emergency closing, early dismissal, and attendance? Yes / No

Notes:

Contact #2: Custody: Yes / No Student lives with: Yes / No
Relationship: Can Pick Up: Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

_____ _____

Phone Call Order

Employer: _____ Home Phone: _____ 1 2 3

_____ 1 2 3

Email: _____ _____ 1 2 3

Please provide me with access to the Schooltool Parent Portal for my child? Yes / No

Contact in case of an emergency closing, early dismissal, and attendance? Yes / No

Notes:

Contact #3: Custody: Yes / No Student lives with: Yes / No
Relationship: Can Pick Up: Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

_____ _____

Phone Call Order

Employer: _____ Home Phone: _____ 1 2 3

Cell Phone: _____ 1 2 3

Email: _____ Work Phone: _____ 1 2 3

Please provide me with access to the Schooltool Parent Portal for my child? Yes / No

Contact in case of an emergency closing, early dismissal, and attendance? Yes / No

Notes: Family Friend

Contact #4: Custody: Yes / No Student lives with: Yes / No
Relationship: Can Pick Up: Yes / No Receives Mailings: Yes / No

Address: _____ Mailing Address: _____

_____ _____

Phone Call Order

Employer: _____ Home Phone: _____ 1 2 3

Cell Phone: _____ 1 2 3

Email: _____ Work Phone: _____ 1 2 3

Please provide me with access to the Schooltool Parent Portal for my child? Yes / No

Contact in case of an emergency closing, early dismissal, and attendance? Yes / No

Notes: Grandma

Please list up to two adults to contact if you cannot be reached in case of an emergency:

1. Name: _____ Telephone: _____

   Permission to pick up student? Yes / No Cell Phone: _____

2. Name: _____ Telephone: _____

   Permission to pick up student? Yes / No Cell Phone: _____

Emergency Release Information

Emergency "Go Home" Information:

In the event my child has to be dismissed early from school, he/she has been advised to:

_____ Go directly home on the bus

_____ Go to the following location (This person must be listed as a contact):

Name: _____ Telephone: _____

Address: _____ Bus: _____

_____

Other Information:

Do you have have any children in your household that have not reached school age? Yes/ No

Name: _____ Date of Birth: _____/_____/_____ Gender: M / F
(last, first) MM DD YYYY

Name: _____ Date of Birth: _____/_____/_____ Gender: M / F
(last, first) MM DD YYYY

Most recent Legal Custody Papers or Court Order of Protection on file in the district? Yes/ No

Notes:

Are you or another parent/guardian of the child an ***active member*** of the Armed Forces and on Active Duty in the Armed Forces? Yes / No

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian **Date**

LYNCOURT SCHOOL
Medical Information Form

Student: _____ StudentID: _____ Grade: _____
School: _____ Homeroom: _____

Child's Doctor: _____ Phone #: _____

1. Has your child received any immunizations or test not previously reported? **If so, please provide MD documentation.**

2. Has your child during the past year had any illness, injury or operation? If so, please write date and nature of illness. _____

3. Is there anything concerning the health of your child, including medications, which the school should know in order to give your child special care? _____

_____

PHYSICALS

- The Lyncourt School District policy states that physical exams are required for all students who are new entrants or in pre-kindergarten, kindergarten, second, fourth, and seventh grades.
- Physicals completed twelve months prior to the start of the current school year are acceptable.
- Those students who do not turn in a completed physical exam will receive a physical from our school physician at the next scheduled visit. Please indicate your preference below.

If choosing your own physician, a copy of the exam must be provided.

____ Will be examined by his/her own physician. Date of appointment is/was _____.

____ I prefer the school physician to do the physical during school hours.

____ My child will be participating in modified sports and needs a sports physical by the school physician.

____ I prefer my private physician to do the sports physical. Date of appointment is/was _____.

Parent/Guardian Consent _____ Date _____

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

Lissette Colon-Collins, Assistant 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 Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

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

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

Yes ☐ ***No*** ☐ ***Not sure*** ☐ ***If yes,** please explain:_____

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

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

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ No ☐ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

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

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

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

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ☐ Mother ☐ Father ☐ Other:_____

Print

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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Lyncourt Union Free School District
Solvay Transportation Department
2707 Court Street
Syracuse, NY 13208

Lyncourt Phone: 455.7571
Solvay Phone: 487.5842

Lyncourt Fax: 455.7573
Solvay Fax: 487.5857

Transportation Request Form

To start, update, or change student's transportation needs.

Today's date: _____

Student Name: _____ ☐ **Male** ☐ **Female**
Last First Middle Initial

Home Address: _____
No. Street

Age of Student: ____ **Date of Birth:** ___/___/___ **Entering Grade:** ____ **in September 20** ____

Note: *Children under the age of 4 cannot be transported on our school buses.*

Parent/Guardian Home Phone Number: _____ **Day Care Number:** _____

Cell Phone Number: _____ **Work Phone Number:** _____

When would you like the change to take place? _____ **(NOTE: 48 HRS. MINIMUM TO PROCESS)**

Check one

☐ ***New To Our District:*** ☐ ***Change in Transportation:***

AM Change:

Current Address: _____ **New Address:** _____

_____ _____

PM Change:

Current Address: _____ **New Address:** _____

_____ _____

Parent(s) Signature: _____ **Print:** _____

NOTE: A NEW TRANSPORTATION REQUEST FORM NEEDS TO BE FILLED OUT EVERY YEAR AND MAILED TO THE TRANSPORTATION DEPARTMENT BY AUGUST 15 OTHERWISE PICK UP AND DROP OFF WILL BE AT THEIR HOME.

NOTE: In case of an "Early Dismissal," we will need to know the address where you would like your child to be transported.

FOR TRANSPORTATION USE ONLY

☐ **Approved** ☐ **Denied Reason** _____

Transportation Department Designee: *Signature:* _____

Bus # _____ **Pick-up Time:** _____ **Pick-up Location:** _____

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment ? ☐ Yes ☐ No

School: Name

Grade

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

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

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

Parent's Signature_____ Date

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

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

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

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

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

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

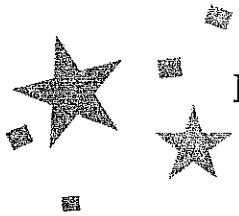
Other problems (Specify):_____

II. Treatment Needs (check all that apply)

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

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

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



LEAD SCREENING (Required)

NYS PUBLIC HEALTH LAW ARTICLE 13, TITLE 10, SECTION 1370 – 1376-A STATES THAT:

- Prior to or within 3 months of initial enrollment, schools are required to obtain from the pre-school child's parent or guardian, proof that the child has had a blood lead test.

- If evidence of blood lead testing has not been received within the 3 months of initial enrollment; the parent or guardian is:
  - to be given information about lead poisoning; and
  - to be referred to primary health care provider or local health department.

- The child's cumulative health record must indicate either the date of the lead screening or that information on lead poisoning referral was provided.

Though the requirements above must be completed, a student lacking proof of lead testing may not be excluded from school (unlike failure to comply with immunization requirements).

See Attachment B for additional information on lead poisoning.

"Great Expectations for Achievement, Respect, and Caring"

Lyncourt Union Free School District

2707 Court Street, Syracuse, New York 13208
Phone: (315) 455-7571 Fax: (315) 455-7573
www.lyncourtschool.org

James J. Austin
Superintendent

Kimberly A. Davis
Principal

Cathryn L. Marchese
Business Administrator

Revisions to School Health Services Regulations Effective July 1, 2018.

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

Vision

- Vision screening for distance and near vision acuity will be required within 6 months of admission to school and in grades Pre K or K, 1, 3, 5, 7, and 11.

Hearing

- Hearing screening utilizing pure tone testing will be required within 6 months of admission to school and in grades Pre K or K, 1, 3, 5, 7, and 11.

Scoliosis

- Scoliosis screening will be required in grades 5 and 7 for girls and grade 9 for boys.

Health Appraisals

- Health examinations will be required in grades PreK or K, 1, 3, 5, 7, 9, and 11.

Dental Certificates

- A dental certificate is requested for all newly entering students and students in Kindergarten, Grades 2, 4, and 7.

A letter will be sent home if there are any findings on the screening done at school that would cause concern or need medical follow-up. Please call the school's Health Office (455-7571) if you have any questions or concerns.

LYNCOURT UNION FREE SCHOOL DISTRICT

Student Health Services

Student Medical History (Confidential)

To the Parent or Guardian: Please complete this form and return it to the School Nurse.

Student's Name: _____ **Date of Birth:** _____

Place of Birth: _____ **Sex:** ☐ **Male** ☐ **Female**
U.S. Citizen? ☐ **YES** ☐ **NO** **If "no", date entered U.S.:** _____ **Green card?** ☐ **YES** ☐ **NO**

Address: _____ **Home phone:** _____
_____ **Cell phone:** _____
Father's full name _____
Mother's full name _____ ☐**MS.** ☐**MRS.** ☐**MISS**
Child resides with: ☐ **BOTH PARENTS TOGETHER** ☐ **BOTH PARENTS ALTERNATING** ☐ **MOTHER**
☐ **FATHER** ☐ **STEPMOTHER** ☐**STEPFATHER** ☐**GUARDIAN** ☐ **OTHER**
Language spoken in home: _____
Names and ages of siblings living in home: _____

Child's Physician _____ **Physician's phone:** _____

Please note: Education law requires that your child's immunization records be submitted to the school at registration, reviewed by a school health official and be in compliance with New York State requirements in order to attend school. Please submit your child's records to the nurse for review at this time. If any immunizations are still required, you will be notified

Birth History:
Weight at birth _____ ☐ **FULL TERM** ☐ **PREMATURE (_____wks)**

Any problems during pregnancy? _____
Any problems during delivery? _____
Sat up at _____**months** **Crawled at** _____**months** **Walked at** _____**months**
First words at _____**months** **Sentences at** _____**months** **Age at toilet training** _____

Has your child had any of the following? (Please check if YES and indicate year if known):

☐**Chickenpox**	**Ear conditions**	**Allergies to** _____
☐**Scarlet fever**	**Frequent Sore Throats**	**Rheumatic Fever**
☐**Measles**	**Mumps**	**German Measles**
☐**Mononucleosis**	**Contact with TB**	**Whooping Cough**
☐**Cancer**	**Serious Injury**	**Other**

****please note: written documentation from MD now required by New York State if child has had chickenpox disease***

Has your child had any surgical operations? ☐ **YES** ☐ **NO (If YES, please indicate year and type of surgery below)**

_____

Has your child had any fractures (broken bones)? ☐ **YES** ☐ **NO**
(If YES, please indicate year and type e.g. ***"left wrist – 2001"*****)** _____

_____

Has your child had any head injuries? ☐ **YES** ☐ **NO** **If so, please give dates and details.** _____

_____

Does your child wear glasses? ☐ **YES** ☐ **NO** **Contact lenses?** ☐ **YES** ☐ **NO**
DISTANCE ☐ ☐ **READING** ☐ **BOTH** **since age** _____

Does your child wear hearing aid(s)? ☐ **NO** ☐ **YES:** **If "Yes":** ☐ **RIGHT** ☐ **LEFT** ☐ **BOTH EARS** **since age** _____

Is your child allergic to bee stings? ☐ **YES** ☐ **NO** **If YES, has your child ever had trouble breathing or needed medical help or injections after a bee sting?** ☐ **YES** ☐ **NO** **If "yes", please describe:** _____

(over)

Does your child have any other allergies? (Hay fever, food, medicine, other?) ☐ **YES** ☐ **NO (If YES, to what is your child allergic to**

_____

Has your child ever had a seizure(s)? ☐**YES** ☐ **NO**
(If YES please indicate type and frequency of seizures, any "aura" or "warning" symptom before seizures, any seizure medication used now or in the past and name of doctor caring for this condition.)

_____
_____

Have you ever been told that your child has a heart murmur? ☐**YES** ☐**NO (If YES, please indicate what age, activity restrictions if any and name of doctor caring for this condition.)**

_____
_____

Is your child taking any medication at this time? ☐ **YES** ☐**NO**
(If YES, please indicate name of medication, dosage and reason for medication.) _____

_____

Does your child need medication during school hours? ☐**YES** ☐**NO**
(If YES, please have your physician complete the attached form. This is a New York State requirement for prescription and non-prescription medication in schools.)

Does your child have diabetes? ☐**YES** ☐**NO**
(If YES, please have your physician complete the attached form and include a complete schedule of glucose monitoring and insulin injection at school. Please provide a glucose monitor to be kept at school.

Does your child require daily medical treatment or procedure during school? ☐**YES** ☐**NO**
(If YES, please indicate name of procedure and provide physician's written order and required treatment supplies, e.g. catheters, feeding tubes.) _____

At previous schools, has your child received Special Education services? ☐**YES (IEP) (504)** ☐**NO**
(If YES, please state type of services e.g. Resource Room, Physical Therapy, Speech Therapy, etc.) _____

_____

Does your child receive counseling now or in the past? ☐**YES** ☐**NO**
(We realize this is sensitive and confidential information. You need not elaborate, but if you would care to discuss the circumstances, please consult the nurse, guidance counselors, psychologist or social worker.)

Is there any other circumstance or condition of which the school should be aware for your child's health, comfort and safety?

_____
_____
_____

THANK YOU FOR PROVIDING THIS IMPORTANT INFORMATION FOR YOUR CHILD'S HEALTH AND SAFETY.

Signature _____ **Date** _____

Relationship to student: _____