Grand Island School District Office
1100 Ransom Road
Grand Island, NY 14072
Phone: (716) 773-8800
Fax: (716) 773-8895

Grand Island High School
1100 Ransom Road
Grand Island, NY 14072
Phone: (716) 773-8820
Fax: (716) 773-8951

Veronica E. Connor Middle School
1100 Ransom Road
Grand Island, NY 14072
Phone: (716) 773-8830
Fax: (716) 773-8983

Huth Road Elementary School
1773 Huth Road
Grand Island, NY 14072
Phone: (716) 773-8850
Fax: (716) 773-8984

Kaegebein Elementary School
1690 Love Road
Grand Island, NY 14072
Phone: (716) 773-8840
Fax: (716) 773-8991

Sidway Elementary School
2451 Baseline Road
Grand Island, NY 14072
Phone: (716) 773-8870
Fax: (716) 773-8985

WELCOME
TO
GRAND ISLAND CENTRAL SCHOOL DISTRICT

Committed to Educational Excellence!

All required enrollment forms and related information are included in this registration packet. Forms are to be completed **prior** to registration and brought with you when you enroll your child.

You will also need to bring the following information:

1. **Original Birth Certificate**. The original will be photocopied by our staff and returned to you immediately. (We cannot accept a Baptismal Certificate or Hospital Certificate.)
2. **Proof of Immunization.** The necessary list is enclosed in this packet. We can accept doctor's verification only.
3. **Driver's License** – For photo proof only.
4. **Proof of Residency** – A primary and a secondary form of proof are required. Please see "Proof of Residency List" for acceptable forms.
5. In the case of divorce and separation, custody papers MUST be on file with the school district.
6. If you have been awarded guardianship of a child, we require these legal papers for registration.
7. Your child's last report card and transcript.

Once all of these materials are complete, contact the District Office. **Registration is by appointment only. Please call (716) 773-8800 Extension 0 to schedule.**

GRAND ISLAND
CENTRAL SCHOOL DISTRICT

CENTRAL REGISTRATION PACKET CHECKLIST

Student Name:_____

Date of Registration:_____

Expected Start Date:_____

- ☐ **Residency Questionnaire**
- ☐ **Registration Form**
- ☐ **Race/Ethnicity Identification (Letter and Form)**
- ☐ **Original Birth Certificate**
- ☐ **If not a US Citizen, passport, and/or VISA to verify length of stay**
- ☐ **Photo Identification of registering parent/guardian**
- ☐ **Proof of Residency (*see next page*)**
- ☐ **Proof of Rental Residency (*must be completed only if applicable*)**
- ☐ **Ethnicity Letter**
- ☐ **Proof of custody (if not living with both biological parents)**
- ☐ **Release of Records (*completed and signed*)**
- ☐ **Home Language Questionnaire**
- ☐ **Original Immunization Record**
- ☐ **Health Appraisal Form – from the health care provider within the last 12 months**
- ☐ **Dental Health Letter and Form**
- ☐ **New Enrollment Health History**
- ☐ **Medication Authorization**
- ☐ **Free & Reduced Lunch Application (*completed and returned, if applicable*)**
- ☐ **Directory Information Opt Out Request (*completed if applicable*)**
- ☐ **Student Account Request Form – Technology Department**

Grand Island Central School District

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of Local Educational Agency (LEA): _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Male Female

Date of Birth: _____ / _____ / _____ Grade: ____ ID#: _____
Month Day Year (preschool-12) (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.

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

GRAND ISLAND CENTRAL SCHOOL DISTRICT

PROOF OF RESIDENCY LIST

It will be necessary for you to provide *one* form of Primary Proof and at least *one* form of Secondary Proof.

Acceptable *Primary* Forms of Proof:

1. Current year residential tax bill (with STAR Rebate) for approved residential real property within the District in the name of the parent or Legal Guardian.

2. Notarized Lease Agreement and rental receipt in the name of a parent or Legal Guardian for improved residential real property within the District. Must include name, address and telephone number of landlord for verification purposes.

3. Residential mortgage statement instrument or Legal statement showing "intent to purchase" in the name of a parent or Legal Guardian which describes real property with a residential address within the District.

Acceptable *Secondary* Forms of Proof:

1. Utility bill (electricity, land line telephone, water/sewer or natural gas or propane) for service at a residential address within the District being billed in the name of a parent or Legal Guardian.

2. Utility company (electricity, land line telephone, water/sewer or natural gas or propane) letter to indicate service scheduled to begin within thirty (30) days at a residential address within the District being billed in the name of a parent or Legal Guardian.

3. Bank statement in the name of a parent or Legal Guardian, addressed to a residential address within the District.

4. U.S. Postal Service verification of change of address to a residential address within the district, in the name of a parent or Legal Guardian.

5. Federal or NYS income tax documentation with preprinted name and address such as a W-2 Form, preprinted label from government or an income tax return with preprinted label. Documentation must be addressed in the name of a parent or Legal Guardian and addressed to a residential address within the District.

6. A certificate of occupancy for residential real estate for real property within the District addressed and/or issued in the name of a parent or Legal Guardian.

7. A policy binder of homeowners or residential renters insurance for residential real property within the District addressed and/or issued in the name of a parent or Legal Guardian.

GRAND ISLAND
CENTRAL SCHOOL DISTRICT

PROOF OF RENTAL RESIDENCY (if applicable)

"New York State Law provides that a pupil's legal school residency is at the legal residency of his/her parents or legal guardian. The payment of taxes alone does not necessarily make the person a legal resident of that district."

This is to affirm that _____, Parent/legal guardian of _____

resides in the Grand Island Central School District at:

_____ **Grand Island, NY 14072**
Number and Street **Apt. #**

As a means of offering proof of the above, the following documentation (check two) is presented herewith:
***One proof of residency must be ownership or rental agreement**

☐ **Insurance – Homeowners/Renters**
☐ **Rental Contract ***
☐ **Sales Contract**
☐ **Cable Bill/Letter**
☐ **Tax Bill/Letter**
☐ **Electric/Gas Bill/Letter**
☐ **Landline Phone Bill/Letter**
☐ **Other:_____**

_____ _____
Landlords Name **Phone Number**

I _____understand that if any of the above is
(Renter Signature)
falsely stated, the status of the above pupil as a student in the Grand Island Central School District shall be terminated.

Sworn to before me this _____

Day of_____, 20_____ _____
NOTARY PUBLIC

For District Office use only:

☐ **School Witness to Documentation Presented**

☐ **Accepted**
☐ **Not Accepted**

_____ _____
(Signature) **(Date)**

11/09

Today's Date:

Grand Island Central School District

New Student Registration

Student's Legal Name _____
Last Name , Suffix (ie Jr) First Name Middle Name

Nickname _____

Date of Birth _____
MM/DD/YYYY

Place of Birth _____
City, State

Grade _____ ☐ Male ☐ Female

Date of Arrival in U.S. _____

First Day of Enrollment _____

Last School Attended _____

Address _____

_____
City, State, Zip

Has the Student Ever attended Grand Island Central Schools before?

Yes or No

If "Yes", provide school, grade and year:

_____

Student Residence #1 (Primary)

HOUSEHOLD LAST NAME: _____

Home Phone Number _____

Effective Date _____

Residence Address _____
Number Street Apt/Lot City State Zip

Mailing (if different) _____
Number Street Apt/Lot City State Zip

(If the student is a member of an additional household, please complete the following)

Student Residence #2 (Secondary)

HOUSEHOLD LAST NAME: _____

Home Phone Number _____

Effective Date _____

Residence Address _____
Number Street Apt/Lot City State Zip

Mailing (if different) _____
Number Street Apt/Lot City State Zip

Rev 12/1/08

Office Use Only

Date Enrolled

Student#

School

Grade

Room

Counselor

Bus

Zone

Date Registered

Proof of Residency _____

Birth Certificate _____

Custody Papers _____

Shot Records _____

Registered By

Enrolled By

Date

Student Relationships and Contacts

1 (Parent/ Guardian)

Last Name	Suffix (ie Jr, III)	First Name	Middle Name	Home Phone	☐ Cell Phone Check for no text alerts	Work Phone	Lives with Student	Allowed to Pick up Student	Receive Mailings
							Y / N	Y / N	Y / N

Parent/Guardian Relationship to Student

☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian
☐ Other _____

Email Address	Gender
	M / F

Street Address
City, State, Zip
Mailing Address (if different from Street Address)
City, State, Zip

2 (Parent/ Guardian)

Last Name	Suffix (ie Jr, III)	First Name	Middle Name	Home Phone	☐ Cell Phone Check for no text alerts	Work Phone	Lives with Student	Allowed to Pick up Student	Receive Mailings
							Y / N	Y / N	Y / N

Parent/Guardian Relationship to Student

☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian
☐ Other _____

Email Address	Gender
	M / F

Street Address
City, State, Zip
Mailing Address (if different from Street Address)
City, State, Zip

3

Last Name	Suffix (ie Jr, III)	First Name	Middle Name	Home Phone	☐ Cell Phone Check for no text alerts	Work Phone	Lives with Student	Allowed to Pick up Student	Receive Mailings
							Y / N	Y / N	Y / N

Contact Relationship to Student

☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Cousin
☐ Friend ☐ Neighbor ☐ Other _____

Gender
M / F

Street Address
City, State, Zip
Mailing Address (if different from Street Address)
City, State, Zip

4

Last Name	Suffix (ie Jr, III)	First Name	Middle Name	Home Phone	☐ Cell Phone Check for no text alerts	Work Phone	Lives with Student	Allowed to Pick up Student	Receive Mailings
							Y / N	Y / N	Y / N

Contact Relationship to Student

☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Cousin
☐ Friend ☐ Neighbor ☐ Other _____

Gender
M / F

Street Address
City, State, Zip
Mailing Address (if different from Street Address)
City, State, Zip

Please List Siblings or Other Children Living in Household

Last Name	First Name	Middle Name	Birthdate MM/DD/YYYY	Gender	Grade	Relationship to Student	School Attending

Parent/Guardian Signature Date

INFORMATION ABOUT SPECIAL EDUCATION UPON ENTRY TO SCHOOL

Chapter 434 of the Laws of 2014

Statute: Section 4402

Effective Date: July 1, 2015

Summary:

This amendment requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification shall be provided to the parents of all students in the district (with and without disabilities) upon their child's entry into public school. Districts may provide this information to parents by directing them to A Parent's Guide to Special Education on the New York State Education Department's (NYSED's) web site, provided that the district includes the name and contact information of the district's Committee on Special Education chairperson or other appropriate special education administrator. NYSED's A Parent's Guide to Special Education is available in both English & Spanish.

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

Spanish: http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

Statute: Chapter 434 of the Laws of 2014

Section 1. Section 4402 of the education law is amended by adding a new subdivision 8 to read as follows:

8. Upon their child's enrollment or attendance in a public school, such school shall notify every parent or person in parental relation of their rights regarding referral and evaluation of their child for the purposes of special education services or programs pursuant to applicable federal and state laws. Such notification may be provided by directing parents or persons in parental relation to obtain information located on the department's website relating to a parent's guide to special education in New York state for children ages three through twenty-one provided the notification shall also contain the name and contact information for the chairperson of the school district's committee on special education or other individual who is charged with processing referrals to the committee in the district. §

2. This act shall take effect July 1, 2015. Effective immediately, the addition, amendment and/or repeal of any rules or regulations necessary for the implementation of this act on its effective date are authorized to be made on or before such date.

Información Sobre Educación Especial al Entrar a la Escuela

Para ver el contenido completo en español sobre Educación Especial por favor visite la página:

http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

Grand Island Central School District
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian:
The *Grand Island Central School District* has adopted a procedure which requires the collection and recording of the ethnic identity of students in the *Grand Island Central School District* in accordance with the federal categories and definitions. The information will be used to:

-Report information to the State and federal Education Departments.
-Plan educational programs and make sure that they are readily available to all students.
-Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the next page. Put a check in the box for the category or categories which best describe your child. The *Grand Island Central School District* understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS
To School Staff: This form will be filed in the student's permanent record as confidential information
To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Education Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

Grand Island Central School District
STUDENT RACIAL AND ETHNIC IDENTIFICATION

FORM SREI

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

English Only

Name of School:

School District Student Identification Number:

Date of Birth (Month/Day/Year): / /

Student Name: Last, First, Middle Initial:

Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

2. **Select one or more races from the following five racial groups** [For question (2) Check (√) all groups that apply to your child; check (√) **at least** ONE box.]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.

☐ **ASIAN**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK**: A person having origins in any of the black racial groups of Africa

☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Signature of Parent/Guardian/Other

Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

Grand Island Central School District

1100 Ransom Road, Grand Island, NY 14072
(716) 773-8800
www.grandislandschools.org

CONSENT TO RELEASE EDUCATIONAL RECORDS

To: _____

_____

_____

I. The undersigned (VI) authorizes *(check as appropriate):*

_____ Release of _____ Copies of _____ Access to

II. Record of _____

_____ _____
Date Date of Birth

III. Records Involved *(check as appropriate):*

_____ Academic _____ Psychological

_____ Standardized Test/State Assessments _____ Attendance

_____ Health _____ Other _____

_____ **Please transfer the student's current IEP in IEP Direct to Grand Island Schools**

IV. Reason for as Request *(check appropriate):*

_____ Transcript to new school/instruction

_____ Employment Considerations

_____ Other _____

V. To be released to the **Grand Island Central School District:**

_____ Grand Island High School, 1100 Ransom Road, Grand Island, NY 14072 Fax 716-773-3503

_____ Veronica E. Connor Middle School, 1100 Ransom Road, Grand Island, NY 14072 Fax 716-773-7818

_____ Huth Road Elementary, 1773 Huth Road, Grand Island, NY 14072 Fax 716-773-8984

_____ Kaegebein Elementary, 1690 Love Road, Grand Island, NY 14072 Fax 716-773-8991

_____Sidway Elementary, 2451 Baseline Road, Grand Island, NY 14072 Fax 716-773-8985

VI. Signature of Parent or Guardian:

_____ _____
Signature Date

_____
Date of Records Request

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:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED 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:

GRAND ISLAND CENTRAL SCHOOL DISTRICT

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ M ❑ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❑ Immunization record attached
❑ No immunizations given today
❑ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ❑ Positive ❑ Negative ❑ Not done Date: _____
PPD: ❑ Positive ❑ Negative ❑ Not done Date: _____
Elevated Lead: ❑ Yes ❑ No ❑ Not done Date: _____
Dental Referral ❑ Yes ❑ No ❑ Not done Date: _____

Significant Medical/Surgical History: ❑ See attached _____

Allergies: ❑ LIFE THREATENING ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____
❑ Seasonal ❑ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ . _____

Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

			Referral
Vision - without glasses/contact lenses	R	L	
Vision - with glasses/contact lenses	R	L	
Vision - Near Point	R	L	
Hearing ❑ Pass 20 db sc both ears or:	R	L	

❑ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❑ Negative ❑ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): ❑ None ❑ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❑ Yes ❑ No Student may self carry and self administer medication ❑ Yes ❑ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❑ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❑ **Specify medical accommodations needed for school:** _____ ❑ None

❑ **Known or suspected disability:** _____ ❑ Please monitor

❑ **Restrictions:** _____ ❑ Please monitor

❑ **Protective equipment required:** ❑ Athletic Cup ❑ Sport goggles/impact resistant eyewear ❑ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❑ Asthma Diabetes: ❑ Type 1 ❑ Type 2 ❑ Hyperlipidemia ❑ Hypertension
❑ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev.9/08*

Grand Island Central School District
New Enrollment Health History

Dear Parent/Guardian:

Please complete this form so that we may be able to generate a cumulative health record for your child. This information is confidential and will only be shared with appropriate school personnel. I hereby give my permission for this information to be shared with appropriate school personnel as needed.

Signature Parent/Guardian: _____ Date: _____

Student's Last Name: _____ First Name: _____

Address: _____ Home Phone: _____

Date of Birth: _____ Birthplace: _____ Grade: _____

Did this student previously attend a Grand Island school? ❑ Yes ❑ No

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Student's History:

Birth Weight: _____ Any special care or treatment shortly after birth or during pre-school? ❑ Yes ❑ No

If so, please explain: _____

Does your child require special shoes, braces, crutches, wheelchair, diet, or have impaired function? ❑ Yes ❑ No

If so, please explain: _____

Is there a history of any hospitalizations, significant injuries or surgery? ❑ Yes ❑ No

If so, please explain: _____

Does your child have any congenital abnormalities or defects? ❑ Yes ❑ No

If so, please explain: _____

Please check all that apply and provide dates where necessary:

❑ Head Injury ❑ Loss of Consciousness ❑ Concussion ❑ Skull Fracture ❑ Frequent Headaches

❑ Heart Murmur ❑ Heart Disease ❑ Chest Pain ❑ Shortness of Breath ❑ EKG, EEG, CT Scan or MRI

List date and describe: _____

❑ Asthma ❑ Bronchitis ❑ Reactive Airway Disease ❑ Breathing or Lung Problems

List date and describe: _____

Student's History (continued)

Has student ever been , or currently being followed by a doctor or clinic for any health problems? ❑ Yes ❑ No

If so, please describe: _____

Is there any mental, emotional or physical condition the school should know about? ❑ Yes ❑ No

If so, please describe: _____

Does this student have any known allergies? *(insects, pets, foods, medication, seasonal, environmental)* ❑ Yes ❑ No

If so, please describe: _____

Has the allergy required emergency treatment or does the student require emergency medication? ❑ Yes ❑ No

If so, please explain: _____

Does this student currently take medication on a regular basis? ❑ Yes ❑ No

If so, for what reason? _____

Medication and Dosage: _____ Is it necessary for school? ❑ Yes ❑ No

Medication and Dosage: _____ Is it necessary for school? ❑ Yes ❑ No

Please check all that apply and provide dates where necessary:

❑ Anemia _____
❑ Asthma _____
❑ Bronchitis _____
❑ Chickenpox _____
❑ Hard to stop bleeding _____
❑ Nosebleeds _____
❑ Diabetes _____
❑ Seizure Disorder _____
❑ Heart Disease _____
❑ Hepatitis _____
❑ Nephritis _____
❑ Pneumonia _____
❑ Rheumatic Fever _____
❑ Scarlet Fever _____
❑ Strep Throat _____
❑ Joint Problems _____

❑ Vision Problems
- ❑ Glasses _____
- ❑ Eyes Patched _____
- ❑ Eye Exercises _____
- ❑ Amblyopia (Lazy eye) _____
- ❑ Color Perception Deficiency _____

❑ Frequent Colds _____
❑ Ear Conditions _____
❑ Fainting Spells _____
❑ Convulsions/Fits _____
❑ Staring Spells _____
❑ Fractures/Broken Bones _____
❑ Operations _____
❑ Serious Injury _____
❑ Stitches (include location) _____
❑ Scoliosis _____
❑ Mononucleosis _____
❑ Dental Caps, Braces or Plates _____
❑ Migraine Headaches _____
❑ Sinus Infections _____
❑ Menstrual Problems _____
❑ Bladder/Bowel Problem _____

❑ Hearing Problems
- ❑ History of Infections _____
- ❑ Tubes _____
- ❑ Hearing Loss _____
- ❑ Wears Aids/ Uses FM System _____

New York State law requires all NEW STUDENTS entering a school district for the first time have a physical examination completed no more than 12 months prior to the entry of school

Please check one of the following:

☐ I give permission for my child to receive a physical at school by the school physician

☐ My child had a physical within the past 12 months on _____, or has an appointment scheduled for a physical on _____. If this option is checked,

Please return the completed physical form and copy of immunizations within 30 days of starting school

Signature Parent/Guardian _____ Date _____

Family History (check all that apply and indicate relationship to child)

- ❑ Asthma _____ ❑ Allergies _____
- ❑ Cancer _____ ❑ Diabetes _____
- ❑ Seizure Disorder _____ ❑ High Blood Pressure _____
- ❑ Stroke _____ ❑ Low Blood Sugar _____
- ❑ Migraines _____ ❑ TB _____
- ❑ Heart Attack Before Age 50 _____ ❑ Other _____

Please list any additional comments or information: _____

Revised 3/09

GRAND ISLAND CENTRAL SCHOOL DISTRICT

Health and Dental Examination Requirements

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 2nd, 4th, 7th, and 10th grade.** The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. This is a request, not a requirement.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K , 2nd ,4th ,7th , & 10th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Sincerely,

School Health Services:

Charlotte Sidway Elementary	Phone: 716.773.8870 x2	Fax: 716.773.8985
Huth Road Elementary	Phone: 716.773.8850 x2	Fax: 716.773.8984
Kaegebein Elementary	Phone: 716.773.8840 x2	Fax: 716.773.8991
Veronica Connor Middle School	Phone: 716.773.8838	Fax: 716.773.8983
Grand Island High School	Phone: 716.773.8827	Fax: 716.773.9049

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 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.

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

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

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

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

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

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

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

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

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

Grand Island Central School District

School Health Services

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. MUST BE COMPLETED BY THE LICENSED HEALTHCARE PRESCRIBER:

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

Name of Student _____ DOB _____

Diagnosis _____ Duration of Treatment _____ O Entire school year

MEDICATION	DOSAGE	ROUTE	FREQUENCY/TIME

Possible Side Effects and Adverse Reactions (if any):

_____

O I have determined that this student is **self directed** and has been educated by me in the proper use of this medication

(Self directed means that this student can be assisted in taking their medication by an adult, in the absence of a school nurse because the student is able to identify the correct medication (color, shape), identify the purpose of the medication, knows the correct dosage (1 pill or 2 puffs), knows what time of day the med is taken and what will happen if they don't take it, and can refuse to take the med if there is a concern)

O This student has my permission to carry and self-administer his/her medication ***(INHALERS AND EPI-PENS ONLY)***

(This student has been educated by me in the proper use of this medication and has demonstrated sufficient maturity to carry this drug)

Prescriber's Signature _____ ***Date*** _____

Name of Healthcare Prescriber _____ ***Phone*** _____

(Please print or stamp)

B. MUST BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child receive the medication as prescribed above by our licensed healthcare prescriber. I will furnish the medication in the properly labeled pharmacy container for prescription medication, or in the manufacturer's labeled container for over-the-counter medication. I understand that the school nurse will administer the medication to my child as prescribed above. Under certain circumstances, such as a field trip where no nurse is present, an adult will supervise my self-directed child taking his/her own medication. I have read and will comply with the procedures for administering medications on the back of this form.

Signature (Parent or Guardian) _____ ***Date*** _____

Telephone: Home _____ ***Cell*** _____ ***Work*** _____

**** PLEASE SEE REVERSE ON PROCEDURES FOR ADMINISTERING MEDICATION ****

Grand Island Central School District
School Health Services

Procedures for Administering Medications

Only those medications which are necessary to maintain the student in school and which must be given during school hours should be administered. Any student who is required to take medication during the regular school day or while participating in school-sponsored activities (e.g., field trips, athletics) should comply with all procedures.

The following procedures for administering medications must be followed to provide safeguards and protection for your child's health. This policy has been implemented district wide. Your school nurse must follow these district regulations for any student who takes medication during the school day.

- **Medication must be brought to school by the parent.** Students are not permitted to transport prescription or over-the-counter medication to school. It must be kept in a container appropriately labeled (by the pharmacy and/or licensed healthcare prescriber). Parents may obtain two labeled containers from the pharmacy, one for home and one for school.

- **Written orders signed by a licensed healthcare prescriber and instructions by the pharmacist must accompany the medication.** These instructions must include the student's name, the name of the medication, the dosage, the route (the way it is to be given), frequency, duration, and any possible side effects. A copy of the prescription and over-the-counter medication request form is available in the Health Office and on the district's website.

- Written permission from the parent must be submitted and kept on record in the Health Office requesting that the school district comply with the licensed healthcare prescriber's signed medication orders.

- **These procedures must be followed for all prescription and all over-the-counter medications.** <u>This includes all cough drops, lozenges, lip balms, skin creams, analgesics, etc.</u> Over–the-counter medications must be in a manufacturer's labeled container.

- During field trips or other school activities, the school nurse will advise classroom teachers in regards to procedures.

- When purchasing Diphenhydramine (otherwise known as Benadryl) as prescribed by your healthcare provider, please consider buying tablets or fastmelts rather than liquid (for easier transport during field trips)

- Students assessed by their licensed healthcare provider as being self-directed may carry and self-administer an inhaler or epi-pen.

- Self-directed students may carry and use their sunscreen at school as long as they have written permission from the parent or guardian to carry and use sunscreen. Self-directed means they are able to recognize that it's sunscreen, know why they are using it, and are able to independently apply the sunscreen. (does not apply to Sidway students)

- Any medication that is not picked up by an adult at the end of the school year will be discarded by the school nurse, as per New York State guidelines.

- **These procedures will be strictly enforced for your child's protection**

Revised and approved by Dr. Ehlenfield 6/2013

2016-17 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 8, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine need to be reviewed only for grades prekindergarten, kindergarten, 1, 2, 6, 7 and 8.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 9 through 12. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should 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	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1 and 2	Grades 3, 4 and 5	Grades 6, 7 and 8	Grades 9, 10, 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)[2]	**4 doses**	**5 doses or 4 doses** If the 4th dose was received at 4 years of age or older or **3 doses** If aged 7 years or older and the series was started at 1 year of age or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine 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 of age or older	**3 doses**	**4 doses or 3 doses** If the 3rd dose was received at 4 years of age or older	**3 doses**
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 of age			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**By Grade 7: 1 dose**	**Grade 12: 2 doses or 1 dose** If the dose was received at 16 years of age 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, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. 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 ages 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years of age 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.
   b. If the fourth dose of DTaP was administered at age 4 years or older, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children ages 7 through 10 years 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 vaccine. A Tdap vaccine (or incorrectly administered DTaP vaccine) received at 7 years or age or older will meet the 6th grade Tdap requirement.
   e. For children 7 years of age or older who received the first dose on or after their first birthday, the immunization requirement is 3 doses. If the first dose was received before their first birthday, then 4 doses are required.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years of age or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years of age or older will meet this requirement.
   b. 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 of age.

4. Poliovirus vaccine (IPV/OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at ages 2 months, 4 months and at 6 through 18 months, and 4 years of age 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 age 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

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. Students in grades kindergarten through 12 must have received 2 doses of measles-containing vaccine, 2 doses of mumps-containing vaccine and at least 1 dose of rubella-containing vaccine.
   c. One dose of MMR is required for prekindergarten.

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 24 weeks of age.
   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 aged less 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 aged 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate vaccine (MenACWY). (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menevo) is required for students entering grade 7.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at age 16 years or older, the second (booster) dose is not required.

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 of age.
   b. If 2 doses of vaccine were received before 12 months of age, only 3 doses are required with dose 3 at 12 through 15 months of age and at least 8 weeks after dose 2.
   c. If dose 1 was received at ages 12 through 14 months of age, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months of age or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years of age or older.

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 of age.
   b. Unvaccinated children 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at age 12 through 15 months.
   c. Unvaccinated children 12 through 23 months of age are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months of age or older, no further doses are required.
   e. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

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

Grand Island Central School District

1100 Ransom Road • Grand Island, New York 14072
Telephone (716) 773-8800 • Fax (716) 773-6279
www.grandislandschools.org

August, 2017

Dear Parent/Guardian:

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. Educational records subject to this protection include all academic, attendance, health, guidance and special service reports. FERPA requires schools to inform parents and students annually of these rights, such as by this notice for the current school year. Under FERPA, parents and students over 18 years of age ("eligible students") have the following rights:

(1) Parents and eligible students have the right to inspect and review the student's educational records within 45 days from the date in which the school receives a request for access.

Parents or eligible students who wish to review their records should submit a written request that identifies the record(s) they wish to inspect to the school principal or other appropriate "school official." A "school official" is a person employed by the district as an administrator, supervisor, instructor or support staff (including health or medical staff and law enforcement personnel), school board member, or a person or company with whom the district has contracted to perform a specific task (such as attorney, auditor, medical consultant, therapist or evaluator.

After processing the written request for inspection of a student's education records, the school official will make arrangements for the access and notify the parent or eligible student of the time and the place where the records may be inspected. A copy fee of $0.25 per page may be charged provided that such fee does not effectively prevent parents or eligible students from exercising their rights to inspect and review these records.

(2) Parents and eligible students have the right to request the amendment of the student's educational records that the parent or eligible student believes to be inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA.

Parents or eligible students who seek to amend a record should submit a written request to the school principal which clearly identifies the part of the record they want changed, and why it is incorrect or misleading. If the school decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and advise them of their right to a hearing and their right to file a complaint with the Family Policy Compliance Office at the U.S. Department of Education. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

Please note that the school is not required to consider requests for amendment under FERPA that: (1) seek to change a grade or disciplinary decision; (2) seek to change opinions or reflections of a school official or other person reflected in an education record; or (3) seek to change a determination with respect to a child's status under special education programs.

(3) Parents and eligible students have the right to consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without their consent.

Generally, schools must have written permission/consent from the parent or eligible student in order to release any information from a student's education records. However, FERPA allows schools to disclose records, *without consent*, to the following parties or under the following conditions:

- to a school official with a legitimate educational interest (i.e., the official needs the record to fulfill his or her professional responsibility);
- to another school district to which the student seeks or intends to enroll;
- to specified officials for audit or evaluation purposes;
- to appropriate parties in connection with financial aid to a student;

- to organizations conducting certain studies on behalf of the school;
- to accrediting organizations;
- to comply with a judicial order or lawfully issued subpoena;
- to appropriate officials in cases of health and safety emergencies; and
- to state and local authorities, within the juvenile justice system, pursuant to specific State law.

In addition, schools are also permitted to release information, without prior written consent of the parents or eligible student, which has been appropriately designated as "directory information" by the district. Grand Island Central School District has designed the following information as "directory information":

- student's name
- address
- telephone listing
- participation in officially recognized activities and sports
- weight and height of members of athletic teams
- photograph
- degrees, honors and awards received
- date and place of birth
- grade level
- enrollment status
- the school most recently previously attended if not Grand Island

NOTE: Specific examples include honor roll, merit roll, annual yearbook, playbills and graduation programs.

Photo/directory information, which is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, two federal laws require local educational agencies (LEAs) such as Grand Island Central School District to provide military recruiters, upon request, with three photo/directory information categories – names, addresses and telephone listings – unless parents have advised the LEA that they do not want their student's information disclosed without their prior written consent.

If you do not want Grand Island Central School District to disclose "photo/directory information" from your child's education records, you must notify the building principal in writing that you do not want "photo/directory information" disclosed. The written notice to the principal about photo/directory information must be received no later than 14 days after the date of publication of the notice (or within 15 days of newly enrolling in the district). A notice is provided below.

(4) Parents and eligible students have the right to file a complaint with the U.S. Department of Education concerning alleged failures by the Grand Island Central School District to comply with the requirements of FERPA.

The name and address of the Office that administers FERPA are:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-5920

Additional information on local school policy may be obtained from building principals or Pupil Services at Grand Island Central School District, 1100 Ransom Road, Grand Island, New York 14072.

Sincerely,

Brian Graham, Ed.D.
Superintendent of Schools

GRAND ISLAND CENTRAL SCHOOL DISTRICT

PHOTO/DIRECTORY INFORMATION

OPT OUT REQUEST

I am exercising my rights under the Family Educational Rights and Privacy Act, to hereby request that all photo/directory information (see sample list attached to this form) of my child not be released. ***We acknowledge that such photo/directory information <u>will not be published</u>* in any form including District publications, such as playbills, yearbooks, websites, newsletters, newspapers, etc.***

Print name of parent or legal guardian: _____

Signature of parent or legal guardian: _____

Signature of student (if 18 or older): _____

Name of student(s) and School(s): _____

_____

_____

_____

NOTE: Please list the first and last name of each student for whom you are authorizing to opt-out of the district photo/directory information.

Please return this form to the following address:

Central Office Registration
Grand Island Central School District
1100 Ransom Road
Grand Island, NY 14072

If you have any questions, please call 773-8800.

**Please note that we are acknowledging that this directory information, regarding your child, <u>WILL NOT</u> be published in any form.*

Grand Island Central School District
Responsible Use Procedure for Technology

Computer Usage:
In order to become a user of the Grand Island Central School District's computer facilities, equipment, and internet accounts, I understand that it is necessary to comply with all District regulations for the use of technology as presently in force and as may be amended from time to time. A violation of the Responsible Use Procedure for Technology may result in the loss of computer privileges, disciplinary action and / or prosecution. I further understand that access to the computer facilities will include filtered access to the Internet.

7315 Student Use of Computerized Information Resources (Acceptable Use Policy)
The Board of Education will provide access to various computerized information resources through the District's computer system ("DCS" hereafter) consisting of software, hardware, computer networks and electronic communications systems. This may include access to electronic mail, so-called "on-line services" and the "Internet." It may include the opportunity for some students to have independent access to the DCS from their home or other remote locations. All use of the DCS, including independent use off school premises, shall be subject to this policy and accompanying regulations. Further, all such use must be in support of education and/or research and consistent with the goals and purposes of theSchool District.

I understand that individuals and families may be liable for violations of District policies and procedures for such use. While every reasonable effort will be made by school district personnel to monitor proper usage and provide Internet filters to questionable materials, I also accept responsibility for guidance of Internet use – setting and conveying standards for my son/daughter to follow when selecting, sharing or exploring information and media. Internet access is a privilege. Students who abuse the acceptable use of technology on the Internet will be removed from access.

I have reviewed the Grand Island Central School District Responsible Use Procedure for Technology above with my son/daughter. In consideration of the privilege of using the Grand Island Central School District networks and in consideration for having access to the information contained on them and an Internet account, I release the Grand Island Central School District from any claims of any nature arising from my son/daughter's use of the Internet.

Request To Deny Computer Usage:

In order to achieve the career development and occupational learning standards articulated by the New York State Department of Education, students will be provided access to instructional materials and processes only available through the use of computers. I understand that if I do not request, in writing, that my child is not to use computers, an account will be created to facilitate such access.

Student Account Request Form
Grand Island Central School District
Technology Department

Requested Service: ☐ **New Network Account** ☐ **Change Network Account**

Section 1 ***Network Accounts***

Student Name (Print):_____

School / Building Attending: _____ Grade Level: _____

Enrollment Date:_____ Student ID: _____

If change is requested, describe change:_____

Parent/Guardian Name (Print): _____

I have reviewed the Grand Island Central School District Responsible Use Procedure for Technology with my son/daughter.

Parent/Guardian Signature:_____ Date:_____

Student Signature (MS/HS only):_____

Section 2 ***Google Apps For Education Account Creation Agreement***

The Grand Island Central School District will provide Google Apps for Education accounts to all students. Students will be able to utilize the account while in school or on another device that has an Internet connection. They will also be able to use some of the tools offline. For more information please see the Parent Information document located on our website at http://Grandislandschools.org/cloud.

As a school district, which operates under the Family Educational Rights and Privacy Act (FERPA), we are responsible for obtaining parental consent for the students' use of an Online Service for any student under 18 years of age.

Please indicate that you give permission for your child to have access to Google Apps for Education through the creation of an account.

_____ Yes, I give permission to create an account for my child.

_____No, I do not give permission to create an account for my child.

Please sign below to indicate you have read and agree to the terms of this form.

_____ _____

Parent/Guardian signature Date