



GREENVILLE
CENTRAL SCHOOL DISTRICT

Greenville, NY 12083
(518) 966-5070 ext. 305
Fax: (518) 966-6033

For Office Use Only					
Enroll Date: _____	Proofs of Residence _____				
Immunization: Y or N	Birth Certificate: Y or N	Other: _____			
Student ID#: _____					
Home School	ES	MS	HS	Restrictions: _____	

STUDENT ENROLLMENT FORM

The information on this form is very important. **PLEASE PRINT CLEARLY.**

Student Name: _____ M or F Grade Entering: _____
(Last First Middle initial) (Circle one)

Social Security #: _____ Date of Birth: _____ Birthplace: _____

U.S. Citizen Yes or No Date entered USA, if born in foreign country: _____

County of Residence: _____

Ethnic category (choose one): White American Indian/Alaskan Native Asian/Pacific Islander
 Black (Non-Hispanic) Hispanic

Physical Address: _____
(Number) (Street) (Town) (Zip Code)

Transportation information:
Exact location of residence with a brief description including color and type of house.

Mailing Address (if different and/or P.O. Box): _____

Previous School District Attended: _____

Previous Home Address: _____

Has your child ever been retained? Yes or No If Yes, What Grade? _____
Has your child ever attended Greenville Central School? Yes or No If Yes, When? _____ Grade _____

Name(s) of Brothers and Sisters (Attach additional sheet if needed.)

Name (Last, First, Middle)	M or F	Birth date (m/d/yy)	Birthplace	Grade	School
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are there any restricted releases for this child? (Documentation required. Please attach.) _____

If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign consent for the release of special education records so that special education services can begin as soon as possible.

Consent for release of special education records signed? Yes No

Parent /Guardian 1 Name: Dr./Mr./Ms. _____
(Last First Middle initial)

Relationship to student: _____

Address (if different from student) _____

Lives with Student Has Custody of Student Should Receive Student Mailings

Telephones:

Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Employer's Name: _____

Work Address: _____

Parent/Guardian 2 Name: Dr./Mr./Ms. _____
(Last First Middle initial)

Relationship to student: _____

Address (if different from student): _____

Lives with Student Has Custody of Student Should Receive Student Mailings

Telephones:

Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Employer's Name: _____

Work Address: _____

If parent/guardian cannot be reached

Emergency Contact 1 Name: Dr./Mr./Ms. _____
(Last name, First name, Middle initial)

Relationship to student: _____

Address (if different from student): _____

Employer's Name and Address: _____

Telephones

Home: _____ Work: _____ Cell: _____

Emergency Contact 2 Name: Dr./Mr./Ms. _____
(Last name, First name, Middle initial)

Relationship to student: _____

Address (if different from student): _____

Employer's Name and Address: _____

Telephones

Home: _____ Work: _____ Cell: _____



REQUIRED IMMUNIZATIONS FORM

Public Health Law 2164 requires that the following immunizations must be received prior to the child being allowed to enter school:

3 OPV
3 DPT, DTaP, or DT (diphtheria-pertussis-tetanus vaccine). FULL DOSES ONLY.
2 MMR or
 2 Measles vaccine
 1 Mumps vaccine
 1 Rubella vaccine
3 Hepatitis B vaccines for all Students K-12
1 Varicella vaccine for all children born on or after 01/01/1998 and all children born on or after 01/01/1994, or physician documentation regarding history of disease.
1 Tdap for all students entering 6th grade and who are 11 years of age or older.

The district needs proof of compliance with this law at the time you register your child into the school district. Adequate proof is written certificate or record from the physician's office, a transcript from the previous school.

If the immunizations have not been completed by the date your child is to enter school, **we must exclude the child from school** until the immunizations have been completed or until proof of satisfactory progress toward this completion is shown. Please be advised that the law requires us to exclude children for up to two weeks if the process is not taking place and that, after two weeks of exclusion, we are required to notify Child Protective Services which is a division of the Greene County Department of Social Services.

STUDENT'S NAME: _____ **Date of Birth:** _____

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
OPV (3)	_/_/_	_/_/_	_/_/_		
IPV (4)	_/_/_	_/_/_	_/_/_	_/_/_	
DPT,DTaP	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_
DT	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_
Measles	_/_/_	_/_/_			
Mumps	_/_/_				
Rubella	_/_/_				
MMR	_/_/_	_/_/_			
Hepatitis B	_/_/_	_/_/_	_/_/_		
Varicella	_/_/_	History of Diseases on	_/_/_		
HIB	_/_/_	_/_/_	_/_/_		
Tdap (Age 11)	_/_/_	_/_/_	_/_/_	_/_/_	_/_/_

Physician's Signature: _____



Ear Health History
For Students Entering Grades K-3
Form to be completed by Parent or Guardian

Child's Name: _____

Parent/Guardian: _____ Child's Age: _____

Please help us better understand your child by answering the following questions:

1. Does your child have normal hearing (when ears are clean and healthy)? _____

2. Did your child ever have ear infections? If so, how many total? _____

Between birth to 1 year old _____	3 to 4 years old _____
1 to 2 years old _____	4 to 5 years old _____
2 to 3 years old _____	5+ years old _____

How long did the ear infections last? _____

How often did they re-occur? _____

3. Has your child had myringotomies and PE tubes inserted? _____
if so, how many times and at what ages? _____

4. Has your child ever been seen by an ear, nose, and throat doctor? _____

5. Has your child ever been seen by an audiologist for hearing testing? _____

6. Has your child received speech/language therapy? _____

If so, at what ages and for how long? _____

Therapy was for: _____	articulation _____
language or other _____	(please explain) _____

7. Has your child received amplification during periods of not hearing? _____

8. Is there anything else in your child's ear health history that may be helpful in understanding your child's educational needs?

9. What concerns do you have about your child and school? _____



HEALTH HISTORY FOR NEW ENTRANTS

This form should be completed and signed by the parent or guardian

Name: _____ Date of birth: _____

Family Physician: _____ Phone: _____

Last visit to M.D. (date, reason): _____ Next M.D. visit (date, reason): _____

Preferred Hospital: _____ Dentist: _____ Last Visit to Dentist: _____

Pregnancy history (gestational diabetes, bed rest, medication needs)

Labor and Birth History (emergency delivery, premature labor, birth trauma, delayed discharge from hospital):

Gestation: ___ Full term ___ Premature Delivery: ___ Normal ___ Cesarean Birth Weight: _____

Growth and Development: Walked at age: _____ Spoke first word at age: _____ Spoke sentences at age: _____

Health History

Serious illness: _____

Serious injury: _____

Surgery: _____

Check if your child has, or has had, any of the following and provide date when appropriate:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Bee Stings | <input type="checkbox"/> History of PE Tubes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Food | <input type="checkbox"/> Eye Conditions | <input type="checkbox"/> Rheumatic Disease |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rubella Disease |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Fainting | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> German Measles | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chest X-ray |
| <input type="checkbox"/> Cold & Sore Throats | <input type="checkbox"/> Hypotonia | <input type="checkbox"/> Tonsil Problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Urinary Reflux |
| <input type="checkbox"/> With Fever | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Without Fever | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Last Vision Exam: |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Measles | <input type="checkbox"/> Vision Specialist: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | Glasses Worn: YES NO |
| | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| | <input type="checkbox"/> Orthopedic Conditions | |

Current Health Status (Please state if your child is, or has been, under treatment, or taking medication:

Health conditions under treatment: _____

Medical provider(s) providing treatment: _____

Medication(s) prescribed: _____

Will medications need to be given while your child is at school?

___ Yes* ___ Not known at this time *Prescription required by Physician

Are there any physical restrictions or limitations for physical education or other activities at school?

___ Yes ___ No *If restrictions or limitations, Physicians written documentation is required

Has your child ever received, or is currently receiving, the following services:

___ OT ___ PT ___ Speech ___ Other

Parent/Guardian signature

Date



GREENVILLE
CENTRAL SCHOOL DISTRICT

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(518) 966-5070 ext. 305
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Date Mailed or Faxed: _____

AUTHORIZATION FOR THE RELEASE OR TRANSFER OF INFORMATION

Student Name: _____

Name and address of school last attended:

School: _____

Address: _____

Phone and/or Fax: _____

The above student has enrolled in our school district. Please forward all school records including health, psychological, discipline including records of suspension, academic and other data. Thank you for your assistance.

MAIL OR FAX TO:

Greenville Central School District
Office of the Registrar
Attn: Lynette Terrell
P.O. Box 129, Rt. 81
Greenville, N.Y. 12083
Fax: (518) 966-6033

Signature of Parent or Guardian
Required for out of state transfer

Date



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HEALTH APPRAISAL FORM

For All New Entrants and Students Entering Grades K, 2, 4, 7, and 10
Completed by Physician

Name: _____ **Date of Exam:** _____
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 _____

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

**** List All Medications/Treatments on page 2 of Health Appraisal Form****

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

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____

REQUIRED:

REQUIRED:

Referral

Body Mass Index: _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> 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: _____

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

Physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

___ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, 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: _____

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

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

Notes: _____

