FRONTIER CENTRAL SCHOOL DISTRICT
Enrollment Application & Registration Form

• **Student Information**: _____ ☐Male ☐Female Grade _____
Last First Middle

Child's Date of Birth: ____/____/____

Mother's Maiden Name: _____

Child's Legal Residence: _____
House No. & Street Apt. No. City/town Zip code

Previous Address: _____
House No. & Street Apt. No. City/town Zip code

If student is ***not*** living with a natural parent (birth parent), state the reason:

_____

_____

Name and phone # of Social Services Caseworker, if any: _____

Name and Address of Each School Previously Attended (including schools of this District, if ever attended):

School Name	Address	Dates Attended	Grades
School Name	Address	Dates Attended	Grades
School Name	Address	Dates Attended	Grades

• **Primary Household Information of Parent/Guardian # 1 (Person Completing this Application)**:
Note: The parent or guardian completing this form must reside in the School District, at the same address indicated above for the student.

_____
First Middle Last

Employer: _____ Occupation: _____

Relationship to Student: _____ Residing at the same address as the student? ☐Yes ☐No

Work Phone: _____ Home Phone: _____ Cell Phone: _____ email address: _____

Current Address: _____
House No. & Street Apt. No. City/town Zip code

☐Own ☐Lease/Rent Length of time living there: _____

If current address is leased or rented, provide full name, address and telephone number(s) of each Landlord:

_____

Most Recent Prior Address: _____
House No. & Street Apt. No. City/town Zip code

☐Own ☐Lease/Rent Length of time living there: _____

• **Information of Parent/Guardian # 2**:

_____
First *Middle* *Last*

Employer: _____ Occupation: _____

Relationship to Student: _____

Work Phone:_____ Home Phone: _____ Cell Phone: _____ email address: _____

Parent/Guardian # 2 resides at same address as Student? □Yes □No (If 'Yes' skip to •Additional Parent/Guardian Information) If 'No', provide current address:

Current Address:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

□ Own □ Lease/Rent Length of time living there:_____

Does this address require student mailings? □Yes □No

Most Recent Prior Address:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

□Own □Lease/Rent Length of time living there:_____

• **Additional Parent/Guardian Information**:
Name of adult who provides health insurance for the child: _____

Name of adult who listed child as a dependent on last year's Federal tax return: _____

Name of adult who will list the child as a dependent on this year's Federal tax return: _____

Student is living with (check only one):

□Both Parents □Mother only □Father only □An Agency □Alone □Guardian(s) □A Spouse/Partner □Foster Parent (DSS-2999)

Joint Custody □ Yes □ No **Note: A copy of most recent court document designating custodial parent/guardian is required.**

If you are not a parent of the child, are you a legal guardian? □ Yes □ No If yes, provide copy of court documents.

If you are not yet a legal guardian, do you plan to file for guardianship? □ Yes □ No

Have both natural parents transferred permanent custody and control of the child to you? □ Yes □ No

Note: The District may require additional written information if the child is not living with either parent.

• **Temporary Living Arrangements**:

The following questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435.
Your answers help determine the services the student may be eligible to receive.

1. Is the child's current address a temporary living arrangement? □Yes □No
2. Is this temporary living arrangement due to loss of housing or economic hardship? □Yes □No

If you answered YES to the above questions, proceed to question 3:

3. Where is the student presently living? (*Check one box.*)
   □In a motel or shelter
   □With more than one family in a house or apartment
   □Moving from place to place
   □In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

• **Sibling Information**:

NAMES OF BROTHERS & SISTERS OF STUDENT & ALL RESIDENTS	BIRTH DATE mo/day/yr	GENDER	GRADE	CURRENT SCHOOL	SCHOOL FOR COMING YEAR	LIVES AT HOME?
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No

• **Emergency Contact Information**:

1. Name:_____ Phone #s: Daytime:_____ Cell:_____ Evening:_____

Address: _____
House No. & Street *Apt. No.* *City/town* *Zip code*

Relationship to child: _____

2. Name:_____ Phone #s: Daytime:_____ Cell:_____ Evening:_____

Address: _____
House No. & Street *Apt. No.* *City/town* *Zip code*

Relationship to child: _____

• **Proof of Residency Submitted by Parent/Guardian #1** (minimum of two required; attach copies):

1._____ 3._____

2._____ 4._____

This page is intentionally blank.

FRONTIER CENTRAL SCHOOL DISTRICT
Confidential Medical Form

State Law requires us to have a medical record for each student enrolled in the Frontier Central School District. Please complete both pages. Without the signed Medical Form, children will not be enrolled. A copy of your child's immunization record is also essential for registration.

Child's Legal Name _____ Grade ____ Date of birth:_____

Address: _____ Phone _____
Street City/town Zip

School: _____ Entry Date: _____ Grade: _____

Prior School: _____
Does your child have any **medical problem or physical limitations** that we should know about to best administer to the child? Is so, please EXPLAIN:
_____
It is essential that we know if your child is on any medication. All current medication should be labeled with your child's name, prescription, and instructions and only given to the school nurse upon registration. **MEDICATIONS, including over the counter remedies such as cough drops, pain relievers, etc. are to be kept in the Health Office.** The only exception is emergency medications for diabetes, asthma, anaphylaxis. You must see the school nurse regarding these situations. Completion of proper forms is also required.

Mother:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Father:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Step Parent:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Step Parent:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Guardian:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Please list two responsible adults with reliable transportation available that the school could contact/release your child to in the event of the parent's absence:

Name: _____ Name_____

Phone #: _____ Phone #: _____

Relationship to child: _____ Relationship to child: _____

Child's MEDICAL PROVIDER _____ Child's DENTIST: _____

Phone # _____ Phone # _____

MEDICAL-SURGICAL RELEASE

In the event of a serious accident or illness, I understand that every effort will be made to contact me if my child needs emergency medical-surgical treatment. However, if it is impractical or impossible to do so, I hereby give permission for my child to be transported to _____ Hospital OR to the nearest Emergency Treatment Center or Hospital to secure proper treatment, as deemed most appropriate by medical personnel. I, the undersigned, do also hereby authorize officials of Frontier Central School District to contact directly the persons named on this form and do authorize the named medical providers to render such treatment as may be deemed necessary in an emergency, for the health of said child.

Parent to Complete **Medical History for:**_____
Child's Legal Name

Does your child have:

☐ Allergies (please specify) Allergic to: ☐ Medication ☐ Bee Stings ☐ Food ☐ Environmental
☐ Other (please specify): _____

☐ Asthma ☐ Diabetes ☐ Ear/Hearing Condition

☐ Fainting Spells ☐ Heart Disease ☐ Eye/Vision Condition

☐ Muscular – skeletal conditions, muscular dystrophy, cerebral palsy, etc.

☐ One of a paired organ (ex: eye, kidney, testicle) please specify: _____

Has your child ever had:

☐ Chickenpox Date: _____ ☐ Head Injury Date: _____

☐ Lead Poisoning Date: _____ ☐ Pneumonia Date: _____

☐ Rheumatic fever Date: _____ ☐ Scarlet Fever Date: _____

☐ Seizures Date: _____ ☐ Other Serious Medical Conditions Date: _____

Please specify type and date for the following if applicable:

☐ Broken Bones _____

☐ Depression, anger, coping, stress problems? _____

Treatment for above _____

☐ Neurological, personality, mental conditions? _____

☐ Serious Injuries: Type: _____ Date: _____

Type: _____ Date: _____

☐ Speech, Physical and/or Occupational Therapy? _____

☐ Learning and/or Reading Difficulties? _____

☐ Surgery (specify type and date) _____

_____

Any other relevant health information _____

_____

_____ _____

*** Signature of Parent/Guardian** **Date**

Please advise us of any changes in these questions so that your child's record will remain current.

Form Revised 7/16

NYSED requires an annual physical exam for new entrants, students in Grades Pre -K, or K 1, 3, 5, 7, 9 and 11th, sports, working permits and triennially for the Committee on Special Education (CSE).

FRONTIER SCHOOLS 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: _____

Concussion Hx ❑Yes ❑ No _____

Significant Medical/Surgical History: ❑ See attached _____

_____

Allergies: ❑ **LIFE THREATENING** ❑ Food: _____ ❑ Insect: _____ ❑ Other: _____

❑ Seasonal ❑ Medication: _____ _____

Any family member under 50 with sudden cardiac death ❑ Yes ❑ No

PHYSICAL EXAM

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

				Referral
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	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: _____

FRONTIER CENTRAL SCHOOL DISTRICT

STUDENT PHYSICAL EXAMINATION

Dear Parent or Guardian,

New York State Education Law mandates that a physical examination on all students who are in the Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade, new entrants, and triennially for students in special education classes. If you prefer to have your own health care provider conduct this examination, please have the form (on the reverse side) completed and returned to school by October 20th. Any health care provider physical completed on or after September 1st of the previous calendar year will be accepted. In accordance with the law, the District nurse practitioner will provide the physical examination for students who do not return the form. A parent or guardian may be present during the examination with advance notification so a time can be arranged.

You will receive a notice if there is any problem identified during your child's physical examination. If notified, please be sure to take your child to his/her health care provider, eye doctor or dentist as soon as possible. Nurses are required to follow up on all referrals sent to you addressing your child. If you would like any assistance in linking with medical providers, health insurance or any other particulars relative to the referral, please do not hesitate to contact your school nurse. If your child requires a modification in the school environment to best meet his/her physical needs, please advise the school nurse as soon as possible. If medications are required during the school day (including those over-the-counter), forms are available from the school nurse that must be completed by the medical provider per the medication administration policy. The medication administration policy can be found in the District calendar or by contacting the building nurse.

SPORTS PHYSICALS

Sports physicals are valid for a period of 12 months. We will accept a physical from your private Physician or Practitioner.

FRONTIER CENTRAL SCHOOL DISTRICT STUDENT EMERGENCY CARD

Date _____ **/School Year** _____

School _____

Grade _____

Room No. _____ **/Locker No.** _____

Birthdate _____

Bus No.: To School _____ **To Home** _____

Student's Name _____
Last **First** **Middle**

Male ☐ **Female** ☐

Address _____

City _____ **Zip** _____

Home Telephone _____

To parent or guardian: To serve your child in case of accident or sudden illness, it is necessary that you furnish the following information for emergency calls:

	Name	**Daytime telephone**	**Cell phone**	**Pager**	**E-Mail address**
Mother					
Father					
Step-parent					
Guardian					

CHILD LIVES WITH: (*Please Circle All that Apply*) **Mother Father Step-mother Step-father Guardian other**

Status of Parents: (*Please Check Appropriate Space/s Below*) **List Date:** (*Separated/Divorced/Death*) _____

( ) Married ( ) Separated ( ) Divorced ( ) Mother Remarried ( ) Father Remarried ( ) Mother Deceased ( ) Father Deceased

Legal Custodial Restrictions: ( ) No ( ) Yes _____ *Copy of Legal Document Must be Provided*

Alternate Site for Emergency School Closing (within walking distance of bus stop):

Name _____ Address _____ Phone _____

Name and Birthdates of Brothers & Sisters under 18 years of age:

Name	Birthdate	Name	Birthdate

List two neighbors or NEARBY adults who will assume temporary care of your child if you cannot be reached:

Name _____ Name _____

Address _____ Tel. _____ Address _____ Tel. _____

Relationship _____ Relationship _____

Please Complete This Section

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Severe Allergies	☐	☐	Chronic Conditions	☐	☐
Diabetes	☐	☐	Eye/Ear Problems	☐	☐	Emotional/Behavior Conditions	☐	☐
Epilepsy Seizure	☐	☐	Asthma	☐	☐	Other	☐	☐

Medication _____

If you answer yes to any of the above please explain:

_____

_____

Primary Care Doctor _____ Dentist _____

Telephone Number _____ Telephone Number _____

"I, hereby, give my permission for my child to be transported to _____ Hospital or to the medical facility deemed most appropriate by medical personnel."

1. I, the undersigned, do hereby authorize officials of Frontier School District to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.
2. In the event that physicians, other persons name on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.
3. To best meet health and safety needs of my child, the nurse **may** share relevant health information with appropriate school personnel. This information will be kept confidential.

_____ _____

Student's Last Name **First** **Initial** **Signature of Parent or Guardian**