East Syracuse Minoa Central School District Registration Form

Registration Office
ESM Central High School
6400 Fremont Road East Syracuse, NY 13057
Telephone # (315) 434-3011 Fax # (315) 434-3351
Email: register@esmschools.org
Registration by Appointment Only
No Walk-in Registrations

Date: ______________

Student Information:		
Last Name, First Name, Middle	**Date of Birth**	
		☐ Male ☐ Female
☐ Select if this student is a foster child		

Address Info:	
Student's Residential Address	
______________________ Street Address ________ Apt. #	( ) Student's Home Phone
______________ City ______ State ________ Zip Code	( ) Student's Cell Phone
	Student's Email: ____________________
☐ *Select if this address is a temporary living arrangement* ☐ *If address is temporary, select if due to loss of housing or economic hardship*	

Name, address and phone of last school attended		
Last School's Name:	Grade:	Year 1st Entered Grade 9: *(if applicable)*
Address:	Phone:	
☐ Select if this student has previously attended ESM Schools		
☐ Select if this student receives Special Education Services or other Educational Services		

Optional

Dominant Language spoken in the Home	
☐ English	☐ Italian
☐ Spanish	☐ Vietnamese
☐ Bosnian	☐ French
☐ Russian	☐ Ukrainian
Other (please specify below)	

The question below is optional:

Ethnicity (choose one)

☐ Hispanic/Latino

☐ Not Hispanic/Latino

Race (Choose all that apply regardless of Ethnicity)

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American

☐ White

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Parent/Guardian:

Parent/Guardian Information:

Last Name, First Name	Custody? Yes/No	Student Lives With? Yes/No
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address ______ Apt. # ______

City ______ State ______ Zip Code ______

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: ______

Employer: ______

Parent/Guardian Information:

Last Name, First Name	Custody? Yes/No	Student Lives With? Yes/No
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address ______ Apt. # ______

City ______ State ______ Zip Code ______

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Other Contacts:

Contact Information:

Last Name, First Name	Custody? Yes/No	Student Lives With? Yes/No
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address ____ Apt. # ____

City ____ State ____ Zip Code ____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: ____

Employer: ____

Contact Information:

Last Name, First Name	Custody? Yes/No	Student Lives With? Yes/No
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address ____ Apt. # ____

City ____ State ____ Zip Code ____

Mailing Address (If Different)

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Additional Contacts:

Additional Contact Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _______________ Apt. # ______

City ______________ State ______ Zip Code ______

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: ______________________________

Employer: ______________________________

Additional Contact Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _______________ Apt. # ______

City ______________ State ______ Zip Code ______

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
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Other Information:

Other Information:

Please let us know if you have any children in your household that have not reached school age yet so we can inform you about programs in the future.

Last Name, First Name: ________________ Date of Birth (mm/dd/yyyy): _______ Relationship to student: _______
Last Name, First Name: ________________ Date of Birth (mm/dd/yyyy): _______ Relationship to student: _______

Active Military/Reservist Information:

Please let us know if you are currently on active duty in the armed forces or active duty reserves, we are required to track that information and it may provide additional funding to ESM.

Parent/Guardian Name __________________________ Parent/Guardian Name __________________________

Parental Opt-Out:

☐ **I do not** want a district calendar mailed to me each school year in August

Report cards are available on our Student/Parent Portal at http://www.esmschools.org/spp. Select the option below to request that a copy be mailed home.

☐ **I prefer a paper copy** of my child(s) report card.

The ESM School District provides the community with news, photos and videos from our schools as well as information about events, activities and achievements. At times we also share student work.

In addition, ESM at times releases "directory information" to outside organizations. This includes a student's name, parents' names, participation in recognized school organizations (including positions held, achievements, athletic records and other matters of public knowledge in the community), height and weight of athletes, dates of attendance, degrees, honors and awards.

ESM provides this information through a variety of mediums including, but not limited to, printed materials (bulletins, newsl etters, etc.), the District website and "social media" (Twitter/Facebook, etc.) as well as information shared with the media (TV/radio/newspapers/magazines, etc.) for their use.

Check below if you wish to "opt out" of these communications.

☐ **I do not** want photos or videos of my child or his/her artwork used by the ESM School District on its website, print or social media (Twitter/Facebook, etc.), or released to the media (TV/newspapers for their broadcast, publication, websites and social media) or to other organizations.
☐ **I do not** want my child's directory information to be shared with **third parties.**
☐ **I do not** want my child's directory information to be shared with **military recruiters.**
☐ **I do not** want my child's directory information to be shared with **institutions of higher education.**

Parent/ Guardian Signature: ____________________________________ **Date:** ___________

Print Name: ____________________________________

Health History Form (to be completed for each student by the parent/guardian)

Date ___________ Student's Name ____ Date of birth ______________

Gender __________ Age __________ Grade __________ School _______________

Medicines: Please list all of the prescription and over-the-counter medicines and supplements (herbal & nutritional) that the student is currently taking.

____

____

____

Do you have any allergies? ☐ Yes ☐ No If **yes**, please identify specific allergy below.

☐ Medicines (Please list) ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______________________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had any discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other ____________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting or unexplained seizures?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

HEAD INJURY / CONCUSSION	Yes	No
26. Have you ever had a head injury or concussion?		
27. How many concussions have you had?		
28. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
MISSING / SINGLE ORGAN	**Yes**	**No**
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
MEDICAL QUESTIONS	**Yes**	**No**
30. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
31. Have you ever used and inhaler or taken asthma medicine?		
32. Is there anyone in your family who has asthma?		
33. Do you have groin pain or a painful bulge or hernia in the groin area?		
34. Have you had infectious mononucleosis (mono) within the last month?		
35. Do you have any rashes, pressure sores, or other skin problems?		
36. Have you had a herpes or MRSA skin infection?		
37. Do you have a history of seizure disorder?		
38. Do you have headaches with exercise?		
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Do you or someone in your family have sickle cell trait or disease?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injury?		
44. Do you wear glasses or contact lenses?		
45. Do you wear protective eyewear, such as goggles or a face shield?		
46. Do you worry about your weight?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or do you avoid certain types of foods?		
49. Have you ever had an eating disorder?		
50. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
51. Have you ever had a menstrual period?		
52. How old were you when you had tour first menstrual period?		
53. How many periods have you had in the last 12 months?		

Explain "Yes" answers here:

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian ________________________________ Date ______________

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Medical Background (to be completed for all students by the parent/guardian)

Student's Name ___________________________________ **Grade** ________ **Birth date** ___________

☐ My child will have a physical with his/her private Health Care Provider.

The following documents are to be completed by a Health Care Provider

1. Section 2 of the Dental Health Certificate (Page 11)
2. Health Appraisal Form (Page 8)

☐ I am requesting a physical examination with the school doctor.

Health Care Provider's Name ___________________________________ Phone # _________________________

Number of children in the family? ____________ Position of this child in the family? _______________

Has your child had any of the following conditions? Please check and explain all that apply.

	Asthma		Ear Conditions/Defect		Scarlet Fever
	ADD/ ADHD		Eye Conditions/Defect		Seizure Disorder/Epilepsy
	Anemia		Heart Disease		Whopping Cough
	Bleeding Tendency		Kidney Disease		Operations
	Bone / Joint Disease		Nervous Disorder		
	Diabetes		Pneumonia		Serious Injuries
	Allergies: (drug, food, environmental)				

Please explain the checked areas here.

Please list any other serious problems this child has had from birth to present:

Does your child wear: (Please circle all that apply)
Glasses Contact Lenses Hearing Aid(s) Orthodontic (Teeth) Braces
Orthopedic Brace: (Please circle) Right, Left or Both; Wrist, Knee, Ankle, Other body part –

Medication Information

Is this child currently taking medication prescribed by a physician? **YES** / **NO.**
If **YES**, please list below.

Name of Medication	Dose and Frequency	Reason Taking Medication
1.		
2.		
3.		
4.		

Please note: If any medication is to be dispensed during school hours, a Form #2525a, Authorization for Dispensing Medication, must be completed by the student's Health Care Provider *and* parent or guardian and brought to the school nurse with the medication. Form #2525a and additional information can be obtained from the school nurse.

Emergency Information

In the event a parent/guardian cannot be reached, I give my permission for emergency medical treatment to be administered to my son / daughter. Also, I give permission for this information to be given to emergency medical personnel.

_____________________________________ _____________________________
Signature of Parent / Guardian Date

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ____________________
Seizures ☐ No	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: ____________________ Date of last seizure: ______________
Diabetes ☐ No	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐Type 1 ☐ Type 2 ☐ HbA1c results: ____________ Date Drawn: ____________

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI____________kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ____________________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: ____________________
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL				☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	____________________	__________
	____________________	__________
	____________________	__________
☐ Additional Information Attached	____________________	__________

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: ____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

East Syracuse Minoa Central Schools
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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: | 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.