SPENCERPORT CENTRAL SCHOOL DISTRICT

Kindergarten Registration Checklist
Taylor Elementary School

Please complete the following and bring with you to registration:

- ☐ Student Registration Packet
- ☐ Confidential Kindergarten Questionnaire
- ☐ New Student Health Information Form

At registration, you will need to bring these additional documents:

- ☐ **Residency**
  To register your child, you must be a resident of the Spencerport School District. Proof of residency is required. Please see below for list of acceptable documents.

- ☐ **Proof of Age and Name**
  Please provide a certified transcript of a birth certificate or record of baptism when you come to register your child(ren). If these documents are not available, a passport may be used to determine your child(ren)'s age. For more information, please contact our District Central Registrar at 349-5114.

- ☐ **Record of Immunization**
  We must have each child's complete shot history from your physician or school ***prior to the first day*** of school. For information regarding immunizations, please visit the website under the District tab to find Student Registration.

- ☐ **Physical exam for your child(ren) required**
  All students new to the District must have a physical exam within the last 12 months. If your child has not had a physical, you may obtain the *Health Appraisal Form* at the Health Office or from the Spencerport Central Schools Website under the District Tab, Student Registration. This form can be mailed to our school any time prior to *the first day of school*.

Proof of Residency:

Please provide ONE item from Category 1 and THREE from Category 2. Three additional documents will be required to complete proof of residency after your child(ren) have been enrolled. The three additional documents must be from three different sources.

Category 1:

- Homeowner - Mortgage Statement, Warranty Deed, School or Property Tax Bill - or-

- Renter – Lease Agreement, Statement from landlord or other third-party that establishes physical address in District- or-

- Dual Residency – Sharing single family home or apartment with another family. Dual Residency Form can be found on our website or upon request from the Central Registrar.

Category 2: (included but not limited to)

- ☐ Pay Stub
- ☐ Utility or other bills
- ☐ Income tax form such as a W-2 form
- ☐ Voter registration document
- ☐ State or other government issued identification
- ☐ Documents issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement); or
- ☐ Evidence of custody of child, including but not limited to judicial custody orders or guardianship papers.
- ☐ Official driver's license, learner's permit or non-driver identification that has name and address imprinted directly on the license, no stickers.

SPENCERPORT CENTRAL SCHOOL DISTRICT

Please read below to begin the registration paperwork.

English

If your primary language of communication is a language other than English, we ask that you call Mr. Anthony Trinchera at 349-5114 to schedule an appointment to complete the registration paperwork. When you schedule an appointment, please let Mr. Trinchera know if you would like an interpreter present at the registration appointment.

عربي (Arabic)

أوراق لاستكمال موعد لتحديد 349-5114 الرقم على ترينشيرا أنتوني بالسيد الاتصال منك نطلب فنحن ، الإنجليزية غير أخرى لغة هي للتواصل الأساسية لغتك كانت إذا .التسجيل موعد في فوري مترجم حضور في ترغب كنت إذا ترينشيرا السيد إخبار يرجى ، موعد تحديد عند .التسجيل

Español (Spanish)

Si su idioma principal de comunicación es un idioma que no sea el inglés, le pedimos que llame al Sr. Anthony Trinchera al 349-5114 para programar una cita para completar el papeleo de registro. Cuando programe una cita, informe al Sr. Trinchera si desea que un intérprete esté presente en la cita de registro.

Türk (Turkish)

Birincil iletişim diliniz İngilizce'den farklı bir dilse, kayıt evraklarını tamamlamak üzere bir randevu ayarlamak için 349-5114 numaralı telefondan Bay Anthony Trinchera'yı aramanızı rica ediyoruz. Bir randevu ayarladığınızda, lütfen Bay Trinchera'ya kayıt randevusunda bir tercümanın hazır bulunmasını isteyip istemediğinizi bildirin.

नेपाली (Nepoli)

यादे तपाईंको सञ्चारको प्राथमिक भाषा अंग्रेजी बाहेक अन्य भाषा हो भने, हामी तपाईँलाई 349-5114 मा श्री एन्थोनी ट्रिन्चेरालाई कल गर्न अनुरोध गर्दछौं र दर्ता कागजी कार्य पूरा गर्न भेटघाटको समय तालिका बनाउन। जब तपाईँ भेटघाटको समय तालिका बनाउनुहुन्छ, कृपया श्री त्रिचेरालाई थाहा दिनुहोस् यदि तपाईँ दर्ता अपोइन्टमेन्टमा एक दोभाषे उपस्थित हुन चाहनुहुन्छ भने।

Русский (Russian)

Если ваш основной язык общения не английский, мы просим вас позвонить г-ну Энтони Тринчере по телефону 349-5114, чтобы назначить встречу для оформления регистрационных документов. Когда вы записываетесь на прием, пожалуйста, сообщите г-ну Тринчере, если вы хотите, чтобы переводчик присутствовал при регистрации.

Українс (Ukranian)

Якщо вашою основною мовою спілкування є інша мова, ніж англійська, ми просимо вас зателефонувати містеру Ентоні Трінчері за номером 349-5114, щоб призначити зустріч для оформлення реєстраційних документів. Коли ви плануєте зустріч, повідомте пана Трінчеру, чи бажаєте ви, щоб під час реєстрації був присутній перекладач.

Tiếng Việt (Vietnamese)

Nếu ngôn ngữ giao tiếp chính của bạn không phải là tiếng Anh, chúng tôi yêu cầu bạn gọi cho ông Anthony Trinchera theo số 349-5114 để sắp xếp một cuộc hẹn để hoàn thành thủ tục giấy tờ đăng ký. Khi bạn sắp xếp một cuộc hẹn, vui lòng cho ông Trinchera biết nếu bạn muốn một thông dịch viên có mặt tại cuộc hẹn đăng ký.

Ελληνικά (Greek)

Εάν η κύρια γλώσσα επικοινωνίας σας είναι μια γλώσσα διαφορετική από τα αγγλικά, σας ζητάμε να καλέσετε τον κ. Anthony Trinchera στο 349-5114 για να προγραμματίσετε ένα ραντεβού για να ολοκληρώσετε τα έγγραφα εγγραφής. Όταν προγραμματίζετε ένα ραντεβού, ενημερώστε τον κ. Trinchera εάν θέλετε να παραστεί ένας διερμηνέας στο ραντεβού εγγραφής.

SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue
Spencerport, NY 14559

Student(s) may not start school until this form has been checked for completeness and mandated residency, immunization and birth date policy proofs are presented to the Spencerport Central School District.

Student Information

Name: _____
(Last) *(First)* *(Middle)*

Gender: Male Female **Birth Date:** _____

Current Legal Residence:

_____
(Street) *(City)* *(State)* *(Zip)*

Previous Address: _____ **No. of years:** _____
(Street) *(City)* *(State)* *(Zip)*

Home Telephone: _____

Housing Questionnaire
CONFIDENTIAL INFORMATION

YOUR ANSWER WILL HELP SCHOOL STAFF DETERMINE IF THE STUDENT IS ELIGIBLE TO RECEIVE ADDITIONAL SERVICES UNDER THE McKINNEY-VENTO ACT. STUDENTS WHO ARE PROTECTED UNDER THE McKINNEY-VENTO ACT **ARE ENTITLED TO IMMEDIATE ENROLLMENT IN SCHOOL EVEN IF THEY DON'T HAVE THE DOCUMENTS NORMALLY NEEDED, SUCH AS PROOF OF RESIDENCY, SCHOOL RECORDS, IMMUNIZATION REORDS, OR BIRTH CERTIFICATE.** STUDENTS WHO ARE PROTECTED UNDER THE McKINNEY-VENTO ACT MAY ALSO BE ENTITLED TO FREE TRANSPORTATION AND OTHER NEEDS.

Where is student(s) currently living? *(Please check one box)*

- ☐ In a Shelter
- ☐ With another family or other person because of a loss of housing or as a result of economic hardship (sometimes referred to as "doubled up")
- ☐ In a motel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

Custody Information

Parents divorced or separated? **Yes** **No**

If yes, name of custodial parent? _____

If there are any restrictions, court documents must be submitted.

Are you the guardian of this child? **Yes** **No**

If yes, please check the box that applies:

☐ **Legal Document** ☐ **Other Document** ☐ **Other Circumstances (explain):** _____

_____

If no, please explain circumstances: _____

_____

Any legal concerns regarding your child that the school should be aware of? Yes No
(Example: Is there any specific person who cannot pick up your child?)

***** Note: District Administration will require additional information if child being registered is not living with either parent.***

Other Children in the Home

Name (Under age 21)	D.O.B.	School Enrolled	Relationship

Other Adults in the Home

Name	Relationship	Work/Cell Phone

School History

Grade Last Attended: _____ Grade(s) Repeated:_____ Present Grade:_____

Date of entry into 9th grade (if applicable): _____

Has your child ever been reviewed by a Committee on Special Education? Yes No

If yes, has your child been receiving Special Education Services? Yes No

If yes, what is your child's classification?_____
Service(s):_____

Has your child ever had a 504 plan? Yes/ No If yes, what is your child's disability?

_____

Accommodation(s) _____

Was the student suspended or expelled from former school? Yes No
Explain:_____

_____

Has the student ever been enrolled in the Spencerport CSD? Yes No

If yes, which building:_____ Date:_____

Name and Address of all schools previously attended: (include any Spencerport schools also)

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

New Entrant Screening, conducted by Spencerport personnel, is part of the enrollment process. NYS law requires school districts to screen new students who are entering a New York public school. Students may be screened in the areas of math, reading, writing, oral expression and motor skill development. The information from the screening is used to provide input in the correct placement of your student. Your student's building will contact you if further testing is indicated by the screening results. Access to your student's screening results is available upon request.

Parent / Guardian Information

Person registering student: _____

Relationship to Student: ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Foster Parent ☐ Group Home Contact ☐ Legal Guardian ☐Other

Student resides with: Mother Father Guardian Foster Parent Self Other

If other, please specify:_____

Parent / Guardian #1 ***(Note: Parent/Guardian #1 must reside at the same address as student)***
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other
Name:
_____
(Last) *(First)* *(MI)*
Address: _____
(Street) *(City)* *(State)* *(Zip)*
Email:_____
Home Phone #:_____ **Cell Phone #:**_____ **Work Phone #:**_____
Employer:_____
Marital Status: **☐Single ☐Married ☐Separated ☐ Divorce ☐Widowed**

Parent / Guardian #2 ***(Note: Only give address and home phone if different from student)***
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other
Name:
_____
(Last) *(First)* *(MI)*
Address:
_____
(Street) *(City)* *(State)* *(Zip)*
Email: _____
Home Phone #:_____ **Cell Phone #:**_____ **Work Phone #:**_____
Employer:_____
Marital Status: **☐Single ☐Married ☐Separated ☐ Divorce ☐Widowed**

Would you like to have a 2nd mailing mailed to parent #2? Yes No

Emergency Contact Information

This person should be able to be contacted in case of illness or emergency with your child at school

Name: _____ Phone #:_____ Cell #:_____

Relationship: _____

Name: _____ Phone #:_____ Cell #:_____

Relationship: _____

☐ Emergency contacts listed above may receive calls with school related information in addition to being contacted in case of illness or emergency. (i.e.: closings, emergency updates or event updates.)

Please Initial

SPENCERPORT CENTRAL SCHOOL DISTRICT

Notice of Proof of Residency and Records Request Authorization

NOTICE

Please be advised that the provision of false information on this registration form could result in a perjury prosecution. In addition, the district reserves the rights to recover from parents, legal guardians or other responsible parties the entire actual cost of educating a student, plus related costs, for the entire period that any non-resident student is enrolled in the District's schools without authorization and/or false pretenses. This includes cost for students receiving special education services, which are considerably higher and vary depending upon the specific program(s).

CERTIFICATION

I, _____ the parent/guardian of _____ declare under penalty of perjury that the above named student resides at the address shown on the document indicated above and attached. I will notify the school within two weeks of residency changes and agree to provide a new residency proof and update signed statement at that time. Non-compliance may jeopardize continued enrollment.

FALSIFICATION OF ANY INFORMATION OR DOCUMENT REQUIRED FOR RESIDENCY VERIFICATION OR THE USE OF THE ADDRESS OF ANOTHER PERSON WITHOUT ACTUALLY RESIDING THERE MAY RESULT IN REVOCATION OF STUDENT ENROLLMENT AND POSSIBLE LEGAL ACTION FOR PERJURY.

AUTHORIZATION

I authorize the request of student records from previous school and give permission to the Spencerport Central School District to verify telephone numbers and addresses. I understand that if the District believes that the information on this is form is no longer correct or that the child being registered no longer lives at the address provided by you, the Spencerport Central School District has the right under New York State Law to investigate and to withdraw that child from the Spencerport Central School District.

Parent/Guardian Name: _____ (Please Print)

Parent/Guardian Signature _____ Date: _____

Proofs of Residency for each family registering students is required by the Spencerport Central School District.

Please provide **ONE** item from Category 1 and **THREE** from Category 2. *Please Note: Extra time is provided to you to provide Category 2 documents if you do not have them at the time of registration.*

Category 1:

- ☐ **Homeowner** - Mortgage Statement, Warranty Deed, School or Property Tax Bill - *or-*
- ☐ **Renter** – Lease Agreement, Statement from landlord or other third-party that establishes physical address in District- *or-*
- ☐ **Dual Residency** – Sharing single family home or apartment with another family. *(This section will be completed when the shared housing is not due to loss of residency because of hardship).* Dual Residency Form can be found on our website or upon request from the Central Registrar.

Category 2: *(included but not limited to)*

- Pay Stub
- Utility or other bills
- Income tax form
- Voter registration document
- Membership documents (e.g. library cards) based on residency
- Official driver's license, learner's permit or non-driver identification
- State or other government issued identification
- Documents issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement); or
- Evidence of custody of child, including but not limited to judicial custody orders or guardianship papers

SPENCERPORT CENTRAL SCHOOL DISTRICT

New Student Heath Information

Student Name: _____ DOB:_____ Gender at Birth:_____

Address: _____ Grade:_____ Phone:_____

Dear Parent/Guardian:

In order to provide our students with a safe and successful start to school, it is important that we are aware of any individual medical concerns. With this in mind, please complete the following and return to the nurse's office.

	NO	YES	If yes, please give details
Allergies			
Asthma (uses and inhaler)			
Seizures or Convulsions			
Surgery			
Sustained a head injury (was unconscious)			
Heart Condition			
Nonfunctional or absence of eye, ear, kidney, testicle, ovary			
Wears eye glasses or contact lenses			
Uses a hearing aid			
Any medical conditions not previously listed			

Additional Medical Alert/Health Concern

_____

_____

Current Medications

Home:_____

School:_____

Emergency Medical Information:

In case your child is involved in a serious accident at school and we are unable to contact you, we have your permission to have your child transported to:

_____

Hospital Student's Physician Physician's Phone Number

_____

Signature of Parent/Guardian or Student over the age of 18 Date

SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue
Spencerport, NY 14559

7513F

Parent and Prescriber's Authorization to Administer Medication in School

Part 1 below is to be completed by family physician.
Part 2 is to be completed by parent or guardian.
Please return by the first day medication is to be given.

Part 1 (Physician please complete)

_____ should receive the medication prescribed by me and described below
(Name of Child)
during school hours.

Name of Medication:

_____

Dosage: _____

Time(s) of administration:

_____

_____

Date to begin medication: _____

Diagnosis: _____

Name of Medication:

_____

Dosage: _____

Time(s) of administration:

_____

_____

Date to begin medication: _____

Diagnosis: _____

_____
Date

_____
Signature of Physician

Part 2 (Parent please complete)

I hereby request the medication described above, prescribed for my child be administered by school personnel as ordered.

Child's name: _____ Physician's Name: _____

Parent/Guardian: _____ Relation to child: _____

Date: _____

* Medication must be in original drug store bottle with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.

SPENCERPORT CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(7240F.7)

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district or for the district to provide relevant information to your healthcare provider. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

I, _____ authorize my child's healthcare provider(s) listed below
Parent/Guardian's name
to release the medical records of my child, _____, _____, to
child's name *date of birth*
the district's medical officer, physical (PT), occupational (OT), speech therapist (ST), counselor, social worker, psychologist and/or school nurse, or to the service provider(s) listed below.

HC Provider: _____ Phone _____ FAX _____
HC Provider: _____ Phone _____ FAX _____
HC Provider: _____ Phone _____ FAX _____
HC Provider: _____ Phone _____ FAX _____

The healthcare provider may disclose the following protected health information: (check all that apply)

- ☐ Immunizations
- ☐ Health Appraisals
- ☐ Past/current medical condition and its impact on attendance, school programming, and/or PT, OT, ST needs
- ☐ All records
- ☐ Other (as listed): _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- ☐ To develop care or therapy plans for routine and emergent school management
- ☐ To design appropriate educational programs
- ☐ To assess school observations/concerns surrounding behavior
- ☐ To assess a medical basis for modification of transportation and/or tutoring (home or district-based)
- ☐ Medication delivery and/or therapy prescriptions for PT, OT, ST
- ☐ At patient's request with no specified purpose
- ☐ Other: _____

Please select one:

- ☐ This authorization is valid for as long as my child is enrolled in the district.
- ☐ This authorization is valid for the entire academic school year 20____-20_____
- ☐ This authorization shall expire on _____/_____/_____ (MM/DD/YYYY)

I acknowledge that I have the right to revoke this authorization at any time by sending written notifications to the Privacy Officer at my healthcare provider's office and to the District Administration Building c/o the Director of Student Services.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for the disclosure of the Protected Health Information before my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

_____	_____	_____
Date	Signature of Parent/Guardian, Patient over 18	Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult student or parent/guardian of the minor child.

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.

_____	_____	_____
Date	Signature of Student (Over 18), Parent or Guardian	Relationship

Updated 03-2021

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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 ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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 ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ 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	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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