Cairo-Durham Central School District

Computer/Internet Access Permission Slip

All students are granted access to computers and the internet in accordance with the District’s policies and curriculum. If you would NOT like your child to be allowed such access, you must opt out. You may do so by signing the affirmation below and returning this form to the principal of your child’s building.

Please be aware that by choosing to opt out, your child may be denied access to certain programs or materials that will be available to others in his/her class. If you choose to opt out, you may change this determination at any time by sending a letter to the principal asking to change your decision, allowing your child computer and internet access.

Student’s Name

________ Yes, my child has permission to use the computer/internet.

________ No, my child does not have permission to use the computer/internet.

__________________________                ________________
Parent Signature          Date
Cairo-Durham Central School District

Media Center Form

( ) C-D Elementary School  ( ) C-D Middle School  ( ) C-D High School

The following information is necessary in order to check out materials from the Media Center:

Student Name: __________________________________________

Date of Birth: ______________ Gender: ( ) Female  ( ) Male

Grade: __________________

Name of Parent/Guardian: _______________________________________

Home #: __________________ Cell #: __________________ Work #: __________________

Mailing Address: ____________________________________________

Media Center Circulation Policy for Middle and High School students:

Students may take out two books at a time for a two-week period.

Office Use Only

Student ID #: 
Cairo-Durham Central School District

Website, Radio & Newspaper Release

Student's Legal Name ________________________________________________________

I give permission for the Cairo-Durham Central School District to use my child’s name and/or picture on the radio, the Cairo-Durham website (www.cairodurham.org) or in a newspaper announcing my child’s accomplishments with his/her school work or activity.

I understand that this permission slip will carry over for every year of my child’s enrollment in the Cairo-Durham Central School District.

( ) Yes ( ) No

______________________________   ________________________________
Parent/Guardian Signature      Date
Cairo-Durham Central School District
Health Office Protocol

Medication Administration: The guidelines for administration of medication in school issued by the NY State Education Dept. requires the following:

Medication must be brought into school by an adult. It may not be transported on the bus by a student. Medication must be in the original container with the student’s name and pharmacy label intact. A written request to administer the medication by the parents is needed. A written order from your physician indicating frequency, side effects, dosage, time and length of time medication is to be given is also needed. Any over the counter medications must be accompanied by the physician’s written order and parental consent.

Whenever possible, parents should give the medication to their children at home. In order for medication to be given in school, the above criteria must be met. Any students who take medications regularly in school either given by the nurse or self administered need an updated order in the health office at the start of each school year. If a student is found to be carrying medication in school, prescription or over the counter, it will be taken from him and the parent will have to come in and pick it up.

Please notify the office if your child is absent due to illness. If they have an injury or contagious disease or have been put on medication while at home, the nurse should be notified. When your child returns to school from any absence, they are required to bring a note giving the reason for their absence and submit it to the main office. A phone call does not take the place of a note. Your child may be required to present a doctor’s note if he or she is absent for more than three consecutive days.

Gym Excuses-A written note from a parent will be accepted on two occasions per month. Excuses for more than two days per month must be written by a doctor.

Leaving school due to illness. All students are required to go through the nurse’s office to be released for illness. The nurse will not give early release passes to students who choose to call their parents on their own. Keeping your child home when they are ill will avoid having to pick them up after you have left for work, etc. It also cuts down on the spread of colds and flu within the building. If your child is running a fever, he should be kept home for 24 hours after their temperature returns to normal. If your child is sent home for conjunctivitis (pink eye) they may not return for at least 24 hours and a doctor’s note will be required upon returning to school.

Health Referrals-Students who receive a referral for vision, hearing, scoliosis or other health concerns need to have a copy of the medication evaluation on file in the health office. Any medication for gym class or classroom activities need to be on file also.

Physical Exams-The law requires students to have a physical on file in the nurse’s office upon entering PreK, kindergarten and in grades 2, 4, 7 and 10, as well as new students to the district. A physical exam is also required within 12 months prior to participation in any school sport. Parents are encouraged to have this done by their own physician if possible. Your family physician will perform a more complete physical and bring immunizations up to date as well. Any student in need of a physical will be expected to have one with the school physician, at the time of his/her visit, if they have not obtained one by their family physician. A copy of the physical exam needs to be on file in the nurse’s office. If you do not want to have your child to have their physical exam in school, you need to notify the nurse. Immunizations must be in compliance with NYS guidelines.

Vision-Distance acuity for all newly entering students and students in Grades K, 1, 2, 3, 5, 7 and 10. Near vision acuity and color perception screening for all newly entering students.

Hearing-Hearing screening for all newly entering students and students in Grades K, 1, 3, 5, 7 and 10.

Scoliosis-Scoliosis (spinal curvature) screening for all students in Grades 5-9.

Dental Certificates- Requested for all newly entering students and students in Grades K, 2, 4, 7 and 10.
Cairo-Durham Central School District
Health Office
BMI Information
2016/17

Please check appropriate school:
( ) C-D Elementary School
( ) C-D Middle School
( ) C-D High School

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student’s body mass index or “BMI”. The BMI helps the doctor or nurse know if the student’s weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student’s health examination. A sample of school districts will be selected to take part in the survey, we will be reporting to New York State Department of Health. If our school is selected to be a part of the survey, we will be reporting to New York State Department of Health information about our student’s weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child’s information excluded from this survey report.

The information sent to the NYS Dept. of Health will help health officials develop programs that make it easier for children to be healthier.

If you do not wish to have your child’s weight status group information included as part of the 2016-2017 Health Dept.’s survey, please print and sign your name below and return this form to:

Tracy Selner, RN & Bonnie Diamond, RN- CD Elementary – 622-3231
Patricia Seymour, RN - CD Middle/High School – 622-0490

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Please DO NOT include my child’s weight status information on the NYS Dept. of Health’s 2016-2017 survey.

______________________________  ________________________________  ________________________________
Print Child’s Name  Child’s Grade/Teacher  Parent’s Signature

______________________________  ________________________________
Print Parent’s Name  Parent’s Signature

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

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, ____________________________, authorize my child’s healthcare provider(s) listed below to release my child’s __________________________ medical records to the district’s medical officer, physical (PT), occupational (OT), speech therapists (ST) and/or school nurse:

Name: __________________________ Phone: __________ Fax: __________
Name: __________________________ Phone: __________ Fax: __________
Name: __________________________ Phone: __________ Fax: __________
Name: __________________________ Phone: __________ Fax: __________

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

_____ Immunizations
_____ Health Appraisals
_____ Past/Current Medical Condition and It’s Impact on Attendance, School Programing, and/or PT, OT, ST needs
_____ Other

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

_____ To develop care of therapy plans for routine and emergent school management.
_____ To design appropriate educational programs.
_____ To assess the impact of the medical condition(s) on school programming and/or attendance.
_____ To share school observations/concerns surrounding behavior.
_____ To assess a medical basis for modification of transportation and/or home tutoring.
_____ 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 the entire academic school year 20__ - 20__.
_____ This authorization shall expire on __________________________ (month, day, year).

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider’s office and to the District Administration Building.

I understand that the revocation of the authorization is not effective if the Healthcare Provider or District has use the authorization for disclosure of the Protected Health Information before receiving 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 redisclosure 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 Patient (Over 18), Parent or Guardian __________________________ Relationship __________________________

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

A signed copy of this authorization must be given to the adult patient or parent of the minor child.
Cairo-Durham Central School District
Health Office
Administration of Medication in School
2016/17

Please check appropriate school:
( ) C-D Elementary School  ( ) C-D Middle School  ( ) C-D High School

To be completed by parent or guardian:

I request that my child _______________ grade __________ receive the medication as prescribed below by our licensed health care prescriber. The medication will be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

______________________________
Signature of Parent/Guardian

______________________________
Date

Telephone: Home ________________ Work ____________________ Cell ________________

To be completed by the licensed health care prescriber:

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

Name of Student __________________________ Date of Birth ________________

Diagnosis _____________________________________________

Medication ___________________________________________

Prescribed Dosage, Frequency and Route of Administration

______________________________
Time to be Taken During School Hours

______________________________
Duration of Treatment

Possible Side Effects and Adverse Reactions (if any)

______________________________
Other Recommendation

______________________________
Name of Licensed Prescriber and Title (Please Print)

______________________________
Signature of Prescriber

______________________________
Date
NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH 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: ___________________________
PDD: ☐ 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: ___________________________

Allergies:
☐ LIFE THREATENING ☐ Food: ___________________________
☐ Other: ___________________________
☐ Insect: ___________________________
☐ Seasonal ___________________________
☐ Medication: ___________________________

PHYSICAL EXAM

Height: ___________________________ Weight: ___________________________ Blood Pressure: ___________________________ Date of Exam: ___________________________ Referral

Body Mass Index: ___________________________ Vision - without glasses/contact lenses

Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 84th ☐ 85th through 99th
☐ 90th and higher

Vision - with glasses/contact lenses

☐ 5th through 84th
☐ 85th through 99th
☐ 90th and higher

Hearing: ☐ Pass 25 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: ___________________________ Dose/Time: ___________________________

Name: ___________________________ Dose/Time: ___________________________

If AM dose is missed at home:

☐ 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 medication is necessary at school or if the morning medication has not been given.

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

☐ Free from contagious & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

☐ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fencer, baseball, floor hockey, softball.

☐ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, rifle, weight train, crew, dance, track, run, walk, jump.

☐ Specify medical accommodations needed for school:

☐ None

☐ Please monitor

☐ Known or suspected disability:

☐ Please monitor

Restrictions:

Protective equipment required:

☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: ___________________________(Stamp below)

Provider’s Signature: ___________________________ Phone: ___________________________

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. 10/3/07
Cairo-Durham Central School District
Athletic Participation Form

Please check appropriate school: ( ) C-D Middle School ( ) C-D High School

Student's Name: ____________________________

Date of Birth: ___________________ Gender: ( ) Female ( ) Male Grade: ____________________________

Father's Name: ____________________________ Home # ____________________________
Cell # ____________________________ Work # ____________________________

Mother's Name: ____________________________ Home # ____________________________
Cell # ____________________________ Work # ____________________________

Mailing Address: ____________________________

**Previous School Information**

Previous School: ____________________________

Sports Played in Previous School

<table>
<thead>
<tr>
<th>Fall Sport: ____________________________</th>
<th>Level &amp; Number of Years Played</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winter Sport: ____________________________</td>
<td>Modified _ _ _ JV _ _ _ Varsity</td>
</tr>
<tr>
<td>Spring Sport: ____________________________</td>
<td>Modified _ _ _ JV _ _ _ Varsity</td>
</tr>
</tbody>
</table>

Previous Address: ____________________________

With whom did you live with: ____________________________

**Academic Information**

Year Entered 9th Grade: ____________________________

Have you repeated a grade in high school? ______ Yes ______ No

Have you attended any other high schools? ______ Yes ______ No

If yes, please list: ____________________________

Cairo-Durham Central School District offers a wide variety of sports for both boys and girls.

Please check all of the sports you may be interested in participating in.

<table>
<thead>
<tr>
<th>Fall</th>
<th>Winter</th>
<th>Spring</th>
</tr>
</thead>
<tbody>
<tr>
<td>______ Cross Country</td>
<td>______ Cheerleading</td>
<td>______ Baseball</td>
</tr>
<tr>
<td>______ Football</td>
<td>______ Boys/Girls Basketball</td>
<td>______ Softball</td>
</tr>
<tr>
<td>______ Golf</td>
<td>______ Bowling</td>
<td>______ Boys Tennis</td>
</tr>
<tr>
<td>______ Boys/Girls Soccer</td>
<td>______ Wrestling</td>
<td>______ Boys/Girls Track &amp; Field</td>
</tr>
<tr>
<td>______ Girls Tennis</td>
<td>______ Boys Volleyball</td>
<td></td>
</tr>
<tr>
<td>______ Girls Volleyball</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form will be forwarded to the Athletic Director.
Cairo-Durham Elementary School

Field Trip Information
2016/17

Several times during the course of the school year, classes arrange for approved field trips to coincide with the academic curriculum, which necessitates transporting students to and from the district. Other student groups such as the student council, chorus and band have occasion to leave the building for rehearsals or other student activities.

We are requesting that parents sign and return this permission slip at the beginning of the school year to cover all trips away from the district during the year. We will, of course, notify you in advance of any activity which would involve transporting your child from the building.

Several times in the past children have not been permitted to accompany their class on a field trip simply because they "forgot" their permission slip and we were unable to contact the parents. Having a permission slip on file for each student would eliminate last minute confusion and disappointment. If at any time you did not want your child to participate in a field trip, you need only notify the school in writing.

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FIELD TRIPS

Student's Legal Name ____________________________________________

Grade/Teacher ____________________________________________

I hereby give permission for my child to attend approved field trips and student activities requiring transportation from the Cairo-Durham Central School District.

( ) Yes ( ) No

__________________________________________________________________
Parent/Guardian's Signature

__________________________________________________________________
Date