Charter School of Inquiry
404 Edison St. Buffalo, NY 14215
Phone: 833-3250 Fax: 831-7947

1. STUDENT REGISTRATION FORM

STUDENT DATA		
Print Name: (First/ Middle/ Last)		Birth Date:
Grade Level:	Gender: Male/Female	Age Today:
Student's Legal Residence: (Street address)		
City/State/Zip		Primary Phone: Secondary Phone:

MAILING ADDRESS (complete only if different from student's legal residence noted above)			
Mailing Address:			
City	State:	Zip:	Home Phone: Secondary Phone:

CHILD CUSTODIAL INFORMATION	
Who has custody of the student currently? (Circle) Both Parents Mother Father Guardian Other: _____	
With whom does the student live? (Circle) Both Parents Mother Father Guardian Other: _____	
I certify that I have legal custody of _____ **Please submit a copy of current custody papers to the school office.** *Student Name (Print)*	
Signature:	**Date:**

FIRST PARENTAL/GUARDIAN CONTACT *(PLEASE PRINT):*			
Name: (First/Last)	Employer:		
Relationship to Student:	Work Phone:		
Address:	City:	State:	Zip:
Preferred method of contact: cell email home phone	Cell:	Home:	
Email:			

SECOND PARENTAL/GUARDIAN CONTACT *(PLEASE PRINT):*			
Name: (First/Last)	Employer:		
Relationship to Student:	Work Phone:		
Address:	City:	State:	Zip:
Preferred method of contact: cell email home phone	Cell:	Home:	
Email:	Authorized to pick up child from school? ☐Yes ☐ No		

FIRST EMERGENCY CONTACT *(PLEASE PRINT):*	
Name: (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Email:	Authorized to pick up child from school? ☐Yes ☐ No

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SECOND EMERGENCY CONTACT *(PLEASE PRINT):*

Name: (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Email:	Authorized to pick up child from school? ☐Yes ☐ No

Additional Individuals Authorized to Pick up Student from School

Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No

Please note that a child will only be released to an adult who is listed on official school forms as authorized for pick up.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**

Family Sibling(s) Name (First/Last)	Age	Gender	Current Grade	School Attending	Lives with Student?
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N

CERTIFICATION

I hereby certify that the student listed on this registration form actually resides at the address specified on page 1.
I further certify that all the information I provided on this form is true and correct. I understand that I must immediately notify the Charter School of Inquiry if the residency of the student changes from the address listed.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Name Printed** **Date**

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2. Proof of Student's Age

Parent/Guardian**,**

Documentation of student's age is required by law to register your child at Charter School of Inquiry. Please provide the school with a clear copy of **one (1)** of the following documents which proves the date of birth of your child. You may bring the document to the school at 404 Edison St., Buffalo, NY 14215 to be photocopied for the child's school file if you do not have access to a copier.

□ Birth certificate
□ Acknowledgement of Paternity
□ Baptismal record
□ Passport
□ State or government ID
□ School photo ID with date of birth
□ Consulate ID card
□ Hospital or health records
□ Military dependent ID card
□ Documents from federal/state/ local agencies ex. (Department of Social Services)
□ Court orders
□ Native American tribal document
□ Records from international aid agencies or voluntary agencies

For CSI Office Use		
Type of Document (attached)	**Name of Staff Verifying Document**	**Date**

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3. Student Racial and Ethnic Identification

All student between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School: **Charter School of Inquiry (CSI)**	
School District Student Identification Number:	**Date of Birth (Month/Day/Year):**
Student Name (Last, First, Middle):	**Grade Level:**

DIRECTIONS TO PARENTS/GUARDIANS

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check only (√) ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

2. Select one or more races from the following five racial groups [For question (2) Check ( ) all groups that apply to your child; check 9) at least ONE box]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit.

☐ **ASIAN**: A person having origins in any of the original peoples of Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

☐ **BLACK**: A person having origins in any of the black racial groups of Africa

☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Signature of Parent/ Guardian/ _____ Date _____

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4. RESIDENCY VERIFICATION FORM AND CHECKLIST

NAME OF STUDENT: _____

Name of Person Establishing Residency: _____

I AM THE (CHECK ONE): ____Parent ____ Legal Guardian ____ Foster Parent

____Relative Caregiver ____ Other: (specify) _____

CONFIDENTIAL INFORMATION

COMPLETE THIS BOX IF IT REFLECTS YOUR CHILD'S CURRENT LIVING SITUATION. Your answer will assist school staff with school enrollment and may enable the student to receive additional services under the McKinney –Vento Homeless Act.

CHECK ONE BOX IF YOU ARE LIVING:

- □ with relatives or others **due to lack of housing**
- □ in a motel/hotel, camp ground, or other similar situation **due to lack of adequate housing**
- □ in a shelter
- □ at a train or bus station, park, or in a car
- □ in an abandoned apartment/building

***IF NONE OF THESE SITUATIONS APPLY TO YOU, PLEASE CONTINUE WITH THE RESIDENCY INFORMATION REQUESTED BELOW.**

RESIDENCE:

I affirm that the student(s) resides at the following street address:

Street Address: _____ Apartment Number/Unit_____

City: _____ State: _____ Zip Code: _____

FALSIFICATION OF ANY INFORMATION OR DOCUMENTS, EITHER WRITTEN OR VERBAL RELATIVE TO THIS VERIFICATION PROCEDURE WILL RESULT IN REVOCATION OF ENROLLMENT.

SIGNATURE OF PERSON ESTABLISHING RESIDENCY: _____ **DATE:** _____

The person establishing residency must return this form with copies of any two of the following documents:

- □ Deed to Home
- □ Rental Agreement/Rental Receipt
- □ Bank Statement
- □ Mortgage Payment Receipts or Coupons
- □ Property Tax Receipt
- □ Driver's License, permit (with matching address)
- □ Pay stub, child support check
- □ Bill from Local Utility Company, Cable TV, etc.
- □ Military Orders (Base Housing)
- □ Declaration of Temporary Residency Affidavits for Homeless Families
- □ Valid Voter's Registration
- □ Custody or guardianship papers with current address
- □ Any Other Legal Document which establishes home Address

The document(s) described as checked above was presented by the person identified above, establishing residency for the student(s) listed above. The student's registration address matches the address on the residency verification documentation.

Signature of CSI staff verifying residency: _____ ***Date:*** _____

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5. LANGUAGE QUESTIONNAIRE (HLQ) Page 1
ALL FORMS MUST BE COMPLETE AND RETURNED TO CSI BEFORE A STUDENT ATTENDS SCHOOL

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated. Thank You.

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** _____ *specify*

2. What language(s) are spoken most of the time to the student in the home or residence? ❑ **English** ❑ **Other** _____ *specify*

3. What language(s) does the student understand? ❑ **English** ❑ **Other**_____ *specify*

4. What language(s) does the student speak? ❑ **English** ❑ **Other** _____ *Specify*

5. What language(s) does the student read? ❑ **English** ❑ **Other** _____ ❑ **Does Not Read** *specify*

6. What language(s) does the student write? ❑ **English** ❑ **Other** _____ **Does Not Write** *specify*

7. In your opinion, how well does the student **understand, speak, read and write English? (Check one box per row.)**

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

(Student Name) (Grade)

_____ _____

Signature of Parent/Guardian **Date**

For CSI Office Use Only	
Determination: ❑ Possible LEP ❑ English Proficient	
Signature of School Personnel:	Date:

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Home Language Questionnaire (HLQ) Page 2

Educational History

Indicate the total number of years that your child has been enrolled in school _____

Indicate is your child has ever been home schooled □Yes □No
If yes, for how long? _____

Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. □**Yes** □**No** □**Not Sure**
If yes, please explain: _____

How severe do you think these difficulties are? □Minor □Somewhat severe □Very Severe

Has your child ever been ***referred*** for a special education evaluation in the past? □ No □ Yes

If referred for evaluation, has your child ever ***received*** any special education services in the past?
□No □Yes **Type of services received:** _____

Age at which services were received (Please check all that apply)

□ Birth to 3 years (Early Intervention) □ 3 to 5 years (Special Education) □ 6 years or older (Special Education)

Does your child have an Individualized Education Program (IEP)? □ No □ Yes

Is there anything else you think is important for the school to know about your child? (e.g. special talents, health concerns, etc.)
_____
_____
_____

In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent/Guardian **Date**

Relationship to student: Mother Father Other: _____

Official Entry Only- Name/ Position of Personnel Administering HLQ
Name: _____ Position: _____

If an interpreter is provided, List Name, Position and Credentials:

Name/ Position of Qualified Personnel Reviewing HLQ and Conducting Individual Interview
Name: _____ Position: _____

Oral Interview Necessary: □ No □Yes

Date of Individual Interview: / /	Outcome of Individual Interview: □ Administer NYSITELL □ English Proficient □ Refer to Language Proficiency Team

Name/ Position of Qualified Personnel Administering NYSITELL

Name: _____ Position: _____

Date of NYSITELL Administration: _____

Proficiency Level Achieved on NYSITELL:
□Entering □Emerging □Transitioning □Expanding □Commanding

*****For students with disabilities, list accommodations, if any, administered in accordance with IEP pursuant to CSE recommendation:***

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6. BUFFALO PUBLIC SCHOOLS YELLOW BUS TRANSPORTATION FORM (2020-2021 SCHOOL YEAR)

BUS TRANSPORTATION

Are you requesting bus transportation for your child(ren)?: (Circle one) : Yes No

BPS transportation form is attached and should be completed and returned to the school. *Please press down hard when completing the form to go through all carbon copies. CSI will submit all completed requests to BPS Transportation Department. If your child is eligible for yellow bus transportation, you will receive a letter directly from BPS. If you are not eligible (living within the .7 mile walking zone for the Charter School of Inquiry), CSI will notify you by letter before school starts.*

If you are not using bus transportation, please acknowledge that your child(ren) will be dropped off and picked up from CSI at the school's arrival and dismissal times:

- **Arrival time: 7:15**
- **Dismissal time: 3:15**

Parent/Guardian Signature: _____

Please Note: Children eligible for busing will be picked up in the morning and will be taken home at the regular dismissal time of 3:15 pm. If you choose to have your child stay for the extended day program (from 3:30 pm to 5:20 pm), you must pick her or him up at school **BEFORE 5:20 pm** as there is no bus transportation after the extended day program.

FOR CSI OFFICE USE ONLY

Date Bus Transportation Requested and faxed to Transportation Dept.: _____
Additional Transportation Notes:

Staff Signature _____

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7. AUTHORIZATION AND REQUEST FOR PERMANENT SCHOOL RECORDS FOR STUDENTS ENTERING GRADES 1-6

Charter School of Inquiry has enrolled the following student: _____ for the coming school year. It is requested that a copy of the school records be released or transferred to the Charter School of Inquiry.

<table>
<tr><th colspan="4">TO BE COMPLETED BY PARENT OR GUARDIAN</th></tr>
<tr><td colspan="4">Name of school your child last attended (19-20 school year):</td></tr>
<tr><td colspan="4">School Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td><td>School Phone:
Fax number:</td></tr>
<tr><td colspan="3">Last Grade Attended:</td><td>Date of Birth:</td></tr>
<tr><td colspan="3">Other Schools Attended:</td><td></td></tr>
<tr><td colspan="4"></td></tr>
<tr><th colspan="4">AUTHORIZATION</th></tr>
<tr><td colspan="4">Parent/Guardian: _____
Print name
Parent/Guardian: _____
Signature
Relationship to Student: _____ Date: _____</td></tr>
</table>

Please include any of the following that may apply to this child. Thank you for your cooperation.

	Student 900 number or other ID		Special education records (IEP, 504 plan)
	Copy of all report cards on file		ELL language and service plan
	Attendance records		Medical record(s)
	Copy of birth certificate		Immunization record(s)
	Custody/ Court papers		Dental record(s)
	Expulsion/ suspension/ Discipline records		Other: _____

Please send all student records to CSI

Via Fax:	Via Mail:	Via Email:
716-831-7947 Attention: Courtney A. Eaton	Charter School of Inquiry 404 Edison Street Buffalo, NY 14215	ceaton@csicharter.org

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8. Publicity Release Permission Form
2020-2021 School Year

Throughout the school year there will be numerous occasions when we will be publishing news about our students. We will also take pictures throughout the school year to use on our website, Facebook page, family communicator and yearbook. We may also contact local media outlets (newspapers, television stations, radio stations, etc.) for informational and educational purposes regarding the programs or curriculum at Charter School of Inquiry.

PLEASE CHOOSE ONLY ONE OPTION BELOW:

I, _____(parent/guardian), ***give*** Charter School of Inquiry permission to use my child's picture and/or name for publicity purposes.

OR

I, _____(parent/guardian), ***do not give*** Charter School of Inquiry permission to use my child's picture and/or name for publicity purposes. It should be understood that by selecting this option the school will not be permitted to use your child's picture and/or name for any publication purposes including the **school yearbook** or via the media outlets stated above.

(**Print please**)

Student's Name _____ Grade_____

Student's Name _____ Grade_____

Student's Name _____ Grade_____

Student' Name _____ Grade _____

Parent/Guardian's Signature _____ Date _____

An **unreturned** Publicity Release Permission Form will be considered as permission **not** given.
A parent or guardian may make a change to the Publicity Release Permission Form by submitting a Publicity Release Permission Revocation Form, available in the school office.

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9. FIELD TRIP PERMISSION FORM 2020-2021

Your child will have the opportunity to participate in planned school field trips. You will be informed in advance about upcoming field trips. Some field trips may require a small fee. You will also be informed about the fee in advance. Please sign below to permit your child to attend the field trips that will be planned. By signing below, you will also give medical consent to treat your child if necessary. This permission form will be kept at the school and will be active for the entire school year. **YOU WILL NOT BE REQUIRED TO COMPLETE ANOTHER PERMISSION FORM**. Please also note that you will need to complete one form for *every* child enrolled in Charter school of Inquiry

I GIVE PERMISSION FOR_____**TO ATTEND THE FIELD TRIP.**
(Student's Name)

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND AGREED TO THE ABOVE AND THAT WE HAVE YOUR PERMISSION TO TAKE YOUR CHILD ON THIS FIELD EXPERIENCE.

Parent Name (Print): _____

Parent/ Guardian Signature:_____

Address: _____

Home Phone:_____ **Work Phone:** _____

Person to contact in an Emergency: _____

Emergency Phone #: _____

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10. Family Income Range Form

Dear Parent/Guardian:

Charter School of Inquiry participates in the Community Eligibility Provision (CEP) under the National School Lunch Program. Under CEP all students receive a breakfast/lunch at no charge for the entire school year. We do not request that you complete an application for free or reduced lunch based on income eligibility. We now are asking parents/guardians to complete a confidential household income form to determine eligibility to receive additional benefits for your child(ren).

Many state and federal programs use socioeconomic status (that is, household and income information) to determine eligibility for their programs. In addition, the primary state funding calculation uses socioeconomic status. By completing this form our school is able to determine eligibility for additional programs your child(ren) may qualify for. *Regardless, your child(ren) will still receive meals at no charge at school.*

You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you.
The information received is combined for all students at CSI to help our school qualify for federal Title I & II funds to support literacy and math instruction, assess educational progress, and decide eligibility for supplemental state and local nutrition programs.

Please use the chart below to determine your household income. Once you identify your level, please check the appropriate response category below. Thank you.

Federal Guidelines for Free/Reduced Lunch Program: PLEASE CIRCLE # IN HOUSEHOLD & INCOME LEVEL THAT BEST PERTAINS TO YOUR HOUSEHOLD. Thank you.

CHECK ONE

# of people in household	1	2	3	4	5	6	7	8	Each additional person (+) add

CHECK ONE

Annual household income less than	**UNDER** $21,775	**UNDER** $29,471	**UNDER** $37,167	**UNDER** $44,863	**UNDER** $52,559	**UNDER** $60,255	**UNDER** $67,951	**UNDER** $75,647	**ADD $(+) 7,696**

SNAP or TANF # (***if applicable***): _____

Student Name: _____ Grade: _____

Parent/Guardian Name (Please Print): _____ Date: _____

Parent/Guardian Signature: _____

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11. Medical Health History Form

Student Name: _____ Grade: _____

Has your child ever had any of the following conditions? (Please check YES to those that apply)

Condition	YES	Condition	YES
Allergies		Chicken Pox	
Asthma		Hepatitis	
Pneumonia/Bronchitis		Rheumatic Fever	
Head Injury/Concussions		Tuberculosis	
Seizures		Diabetes	
Spinal Injury		Speech Problems	
Hearing Problems/Deafness		Skin Conditions	
Vision Problems		Testicles: Injury/Surgery/Hernia	
Cystic Fibrosis		Surgery	
Cerebral Palsy		Heart Condition	
Dental Problems		Lead Poisoning	
Vision Problems/Glasses		Muscle Problems	
ADD/ADHD		Sickle Cell Disease	
Behavioral Problems		Frequent Urination/Wetting	
Emotional Problems		Bleeding Problems	
Speech Problems		Bowel Problems	

If you answered YES to ALLERGIES, please list them below & explain the necessary procedure if a reaction were to occur:

_____
_____
_____
_____

If you answered YES to ANY OTHER CONDITION, please explain below:

_____
_____
_____
_____
_____

Please describe any other important health-related information about your child that we should be aware of:

_____
_____
_____
_____
_____

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12. First Aid and Emergency Release

I authorize the Charter School of Inquiry school staff members who are trained in the basics of first aid and CPR to administer first aid and/or CPR to my child when appropriate and necessary.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. In the event of an emergency requiring medical attention for my child, if I cannot be reached or if the school determines that delay would be dangerous to my child's health, I hereby authorize the school's staff members to secure the necessary medical treatment for my child.

Student Name: _____ **Grade**: _____

The above emergency and medical information and release is provided by:

Parent/Guardian Name (PRINT): _____

Parent/Guardian Signature: _____

Date: _____

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13. New York State Immunization Requirements

The shaded boxes indicate that these doses are not routinely given. However, if your child has received them, please write the date in the shaded box.

Attention Parent/Guardian: **THIS FORM IS TO BE FILLED OUT BY YOUR CHILD'S PHYSICIAN**. They may choose to attach a copy of your child's immunization history to this **form OR ENTER THE MONTH, DAY, AND YEAR for all vaccines your child has received**. A child's immunization history must include all of the following vaccines to be considered fully immunized and be in compliance with NYS requirements.

Type of Vaccine	1st Dose (Mo/Day/Year)	2nd Dose (Mo/Day/Year)	3rd Dose (Mo/Day/Year)	4th Dose (Mo/Day/Year)	5th Dose (Mo/Day/Year)
Diptheria, Tetanus & Pertussis (DTaP, DTAP, DT) • For children age 6 years and younger • Final dose on or after age 4 years					(5th dose not required if 4th dose given on or after the 4th birthday)
Tetanus and Diptheria (Td) • For children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Polio (IPV, OPV) • Final dose on or after age 4 years (For children 4 years of age or older who have received less than 3 doses, a total of 3 doses are required. If both OPV and IPV were administrated as part of a series, a total of 4 doses should be received, regardless of the child's current age)					
Measles, Mumps, and Rubella (MMR) • Minimum age: On or after 1st birthday					
Hepatitis B (HepB)					
Varicella (Chicken Pox) • Minimum age: on or after 1st birthday • Vaccine or disease history required.					

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14. Exemption to State Immunization Law

Student's Name _____ Grade _____

There is only one exemption that can be recognized by NYS for exemption to State Public Health Law Section 2164.

1. **Medical Exemption:** If the student's physician believes the immunizations are medically inadvisable for reason of medical contraindication, history of disease, or laboratory evidence of immunity. A written statement to that affect signed by the physician/primary care physician must be given to the school each school year.

Please be aware that students who have a waiver of immunization will be excluded from school in the event of an outbreak of a disease for which the student is not immunized.
I have read the requirements for immunizations of my child for entry & attendance at school (listed on the previous page) and agree to comply with New York State Public Health Law as explained above.

Parent/Guardian Signature: _____ Date: _____

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15. PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name of student:_____ **DOB:**_____

Diagnosis:_____

A. To be completed by physician:

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

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

DURATION OF TREATMENT: 2019/2020 school year (including any summer sessions) Other _____

Please note: Medications and treatments will not be administered on early release days, with the exception of emergency medications, procedures and treatments.

Possible Side Effects and Adverse Reactions (if any): _____

PLEASE CHECK ONE:

_____ I deem this child to be **NON SELF –DIRECTED** and understand that administration of oral, topical, inhalant, and injectable medication must remain the responsibility of the school nurse, licensed practical nurse under the direction of the school nurse, physician or parent.

_____ I deem this child to be **SELF-DIRECTED** and understand that the school nurse, or other designated person in case of absence of the school nurse (**including fieldtrips**) will supervise administration of medication.

_____I deem this child may **SELF-ADMINISTER** and **SELF-CARRY** their own medication with approval of the **school nurse.**

Physician Signature: _____ Date: _____

Address: _____ Phone: _____

Please note: The school nurse will assess the child's ability to be considered self-directed and/ or able to self- administer/carry their medications. The school nurse is responsible for making the final determination of self-direction and/or the ability to self-administer/carry medications.

B. To be completed by the parent/guardian:

I have consulted with my child's physician and agree with his/her recommendations. I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled container from the pharmacy.

Parent/guardian signature: _____ Date: _____

Telephone: Home: _____ Cell: _____ Work: _____

***Medication must be in original pharmacy labeled container with specific orders and name of medication.**
***Medication and refills must be brought to school by parent/guardian or responsible adult.**

Plan reviewed with parent(s)/guardian(s):

Nurse signature: _____ Date: _____

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16. RELEASE OF INFORMATION FORM

This form allows exchange of important health information for your child between the School Nurse and their Medical Providers. All records obtained will be kept confidential. Please contact your School Nurse if you have any questions.

Student's Name			
DOB			
Parent/Guardian			
Address			
City		State	Zip
Phone			

I hereby authorize the release of information necessary for health care to:	
Return to: *(School Name)*	**Charter School of Inquiry**
Address	**404 Edison Street Buffalo, NY 14215**
Telephone/ fax	**716-833-3250/ fax 716-831-7947**

FROM		
Health Care Provider		
Address		
Phone		Fax
Regarding Name		
Specific Information		

Signature of Parent/Guardian	
Relationship to Student	
Date	

Charter School of Inquiry
404 Edison St. Buffalo, NY 14215
Phone: 833-3250 Fax: 831-7947

17. Dental Health Certificate

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, 2,4,7, &10. Your child may have a dental check-up during this school year to access his/her fitness to attend school. Please complete section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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/Guardian (Please Print)

Child's Name:

Will this be your child's first oral assessment?
YES NO

School: **Charter School of Inquiry**

Grade Level: K 1 2 3 4 5 6

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

Section 2. To be completed by the Dentist/ Dental Hygienist

The Dental condition of _____ on _____(date)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Circle one:

YES, the student listed above is in fit condition of dental health to permit his/her attendance at the public school.

NO, the student listed above is not in fit condition of dental health to permit his/her attendance at the public school.

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/ Dental Hygienist name and address (please print or stamp)

Dentist's/ Dental Hygienist'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 ½mm 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 cavity 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 cavity 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.

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