OAK HILL SCHOOL

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext.110 FAX 518-399-6140

Student Information

Please Print

Date _____

Name _____ DOB _____

Address _____ Grade _____

_____ Phone _____

Enrollment Date _____ Home School District _____

.....

Parent/Guardian _____ Relationship _____

Mother _____ Daytime Phone _____
Occupation _____ Company Name _____
Email Address _____

Father _____ Daytime Phone _____
Occupation _____ Company Name _____
Email Address _____

Other _____ Daytime Phone _____
Occupation _____ Company Name _____

Two people to be notified when parents/guardians cannot be reached

_____ _____ _____
Name Relationship Daytime Phone

_____ _____ _____
Name Relationship Daytime Phone

Family doctor

_____ _____
Name Phone

7/13

OAK HILL SCHOOL

Application for Admission

Please Print

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext. 110 FAX 518-399-6140

Student Name _____ Date _____

Address _____ Phone (___)_____

_____ County _____

Date of Birth: _____ Age ____ Natural ___ Adopted ___

Ethnicity: ___Caucasian ___ Black ___ Hispanic ___ Native American ___ Asian

Guardian(s): _____ Relationship: _____

_____ Relationship: _____

Names, ages and relationship of others living in the household:

_____

_____

_____

Home School District: _____

Present School: _____ Grade ___ Teacher _____

Previous Schools	Dates Attended	Grade

OAK HILL SCHOOL

Publications Release and Consent Form

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext.110 FAX 518-399-6140

Student Name _____

	Yes	No
I hereby grant permission to Oak Hill School to use photographs of my son/daughter in school publications which highlight student activities such as, but not limited to, the school yearbook and/or brochure.	___	___
I hereby grant permission to Oak Hill School to arrange for public newspaper coverage of student activities which may include the photograph and name of my child.	___	___

_____ _____

Parent/Guardian Signature Date

THIS RELEASE AND CONSENT IS VALID DURING ENROLLMENT AT OAK HILL SCHOOL

OAK HILL SCHOOL

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext.110 FAX 518-399-6140

Transportation Permission Form

Updated July 2017

Student Name _____

TRANSPORTATION

My child, _____, has my permission to be transported by Oak Hill staff for all regular school activities and field trips. He/she may be transported off campus for gym class, Friday earned activity, and summer swim times. I will be notified of all other field trips and/or off campus activities before my child is transported.

_____ _____

Parent/Guardian Signature Date

THIS RELEASE AND CONSENT IS VALID DURING ENROLLMENT AT OAK HILL SCHOOL

OAK HILL SCHOOL

Restraint Policy Agreement

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext. 110 FAX 518-399-6140

Student Name _____

RESTRAINT POLICY:

In the event of a student's behavior which constitutes a threat of injury to her/himself or others, or is likely to result in serious damage to property, s/he will be restrained by Oak Hill staff members, who are trained in appropriate restraint techniques, until s/he demonstrates enough self-control and readiness to safely re-entry regular activities.

I have read and understand the Restraint Policy.

_____ _____

Parent/Guardian Signature Date

THIS RELEASE AND CONSENT IS VALID DURING ENROLLMENT AT OAK HILL SCHOOL

OAK HILL SCHOOL

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext.110 FAX 518-399-6140

Professionals Involved with Student Medications

Please Print

Student Name _____ Date _____

Doctor:

_____
Physician's Name Phone

_____
Address

Counseling & Mental Health Services: Please attach additional pages as necessary
(Please include any psychiatrists, counselors, case managers, etc.)

_____
Name Phone

_____
Address

_____
Name Phone

_____
Address

_____
Name Phone

_____
Address

Medications:

Is child presently receiving medications? Yes _____ No _____

Medications taken at home:

Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency

OAK HILL SCHOOL

39 Charlton Road, Scotia, NY 12302
Telephone: 518-399-5048 Ext. 110
FAX: 518-399-6140
E-mail: oakhill@oakhill.org

David Mitchell
Executive Director

Authorization to Release Information

Student Name _____ DOB _____
Address _____
_____

Provider Name: _____
Provider Address: _____
_____
Provider Phone: _____

I authorize written/verbal records to be released/exchanged with:

Oak Hill School
39 Charlton Rd.
Scotia, NY 12302
(518) 399-5048 Fax (518) 399-6140

Check all records to be released:

___ Medical Records ___ Physical Exams ___ Immunization Records
___ Medication Records ___ Evaluations/Diagnostic Reports ___ Provider notes
___ Achievement testing ___ Attendance ___ Academic/behavior data
___ Report Cards/progress reports

This protected information is disclosed for educational and behavioral programming and may not be shared with any other entity without express written consent from the parent/guardian.
You may refuse to sign this authorization.
You have the right to inspect or copy any protected information shared.
You may revoke this consent in writing by sending notification to Oak Hill School at the above address. Your notice will not apply to actions taken prior to the date the written revocation is received.

Parent/Guardian Name: _____
(please print)
Parent/Guardian Signature: _____
Address: _____
_____
Phone: _____
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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ 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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

OAK HILL SCHOOL

Health Appraisal Release

39 Charlton Road, Scotia, NY 12302
518-399-5048 ext. 110 FAX 518-399-6140

Name of Student _____

New York State law requires that all students entering Pre-K or K, 1st, 3rd,5th, and 7th grade along with those students entering a school district for the first time have a physical examination.

For your convenience we are enclosing a Health Appraisal form which includes immunization information for your health care provider to complete. Please return this form to the school. If the form is left at the doctor's office, please have a stamped envelope with the school's address so the health appraisal form may be sent to the school nurse. Your physician may also fax the physical to the school at 399-6140. If you have any questions, please call the school nurse.

We are requesting that your child's health care provider complete Body Mass Index information on the Health Appraisal Form. Please request that your health provider complete that needed information in order to have a completed Health Appraisal on file at the school.

If your child has a physical scheduled during the school year, please complete the Health Appraisal Release form with the scheduled date and return to the school nurse.

Please keep in mind that students who are entering 6th grade, who are 11 years of age or older must receive an immunization containing tetanus toxoids, diphtheria, and acellular pertussis (Tdap). Students entering 7th grade must have 1st dose of the meningococcal vaccine.

_____ has been or will be examined by the family doctor on _____
Name of student date

_____ _____
Signature of parent or guardian date

Oak Hill School
39 Charlton Rd
Scotia, NY 12302
Phone: 518-399-5048 Fax: 518-399-6140

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____

OAK HILL SCHOOL

39 Charlton Road, Scotia, NY 12302
Telephone 518-399-5048 ext 110
FAX 518-399-6140

Provider and Parent Permission to Administer Medication at School/School Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan; or after the nurse determines my child can take their own medications; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____
Parent/Guardian Signature Date

_____ _____
Email Phone Where We Can Reach You ☐ Check if Cell

To Be Completed By Health Care Provider-Valid for 1 Year

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

Note: Medication will be given as close to the prescribed time as possible, but may be given up to one hour before or after the prescribed time. Please advise if there is a time-specific concern regarding administration.

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, carry glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____ Stamp
Name/Title of Prescriber (Please Print) Date

_____ _____
Prescriber's Signature Phone

_____
Email

Return to Oak Hill School Nurse, 39 Charlton Rd, Scotia NY 12302

Phone: 518-399-5048 fax: 518-399-6140

OAK HILL SCHOOL

Handbook Acknowledgement

39 Charlton Road
Scotia, NY 12302
518-399-5048 ext. 110 FAX 518-399-6140

Student Name _____

RULES AND POLICIES

I have received the **Oak Hill Handbook for Parents and Students.**

I agree to abide by the rules and policies set forth in this handbook.

_____ _____

Parent/Guardian Signature Date