



2758 Main Street P.O. Box 35 Crown Point, New York 12928
Phone 518-597-3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

New Student Enrollment Checklist

The following packet contains forms that must be completed, signed by parent/guardian and returned to Crown Point Central School. Please ensure all items are completed and all required documentation is present at the time of registration. Incomplete packets may delay the student's start date.

Section 1: Required Legal & Residency Documentation

The following original documents must be provided for photocopying by the registrar:

- Proof of Residency (2 Documents Required):** (All items must have parent/guardian name and address within the school district.) Accepted items for proof of residence include Utility bills (gas/electric/water), lease agreement, or mortgage statement dated within the last 30–60 days, driver's license, bank statement, pay stub, official post office change of address form.
- Birth Certificate:** (Official copy required)
- Social Security Card:** (Copy for student records)
- Custody Paperwork / Court Orders:** (If applicable; must be the most recent certified copy)
- Military Orders:** (Required if the parent/guardian with whom the student lives with is active in the military; must show the current address)

Section 2: Required Medical & Health Records

- Current Immunization Record:** (Must meet state requirements)
- Health Exam / Physical:** (Must be dated within the last 12 months)

Section 3: Standard Registration Forms

(Please complete and sign the following forms included in this packet)

- Housing Questionnaire:** (Standard residency status assessment)
- New Student Enrollment:** (Core student and family data)
- Emergency Contact Information:** (List of authorized individuals for pickup/emergencies)
- Release of Information Form:** (Permission to request records from previous schools)
- Transportation Request**
- Student Racial & Ethnic Form:** (Required for state/federal reporting)
- Special Education Information Sheet:**
- Internet Permission/Student Agreement Email Form**

(Continued on back) →



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- Walking Field Trip Permission Slip
- Photo/Video Media Release Opt-Out Form
- Home Language Survey
- Parent Portal Information
- Pesticide application notice
- Community Eligibility Provision (CEP) Form
- Digital Equity Survey
- NYSPHSAA Transfer Notification (High School Only)

Section 4: **Health Information**

- School Nurse Letter
- Health Services Provided
- Health Service Recommendations
- Immunization Record State Requirements
- School Entry Questionnaire
- Health Survey
- Hearing Questionnaire
- Vision Questionnaire
- Allergy Information
- Medicaid Consent
- Student Medication Policy
- Severe Food Allergy Alert
- Head Lice Information Sheet
- Lead Screening Requirement
- Health Insurance Information
- Sample Health Examination Form (to be completed by physician only)
- Sample Dental Health Certificate (to be completed by Dentist/Hygienist Only)



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Note to Schools/LEAS: Please assist students and families with filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents part of the registration packet.

Housing Questionnaire

Name of LEA: _____

Name of School: _____

Name of Student: _____ D.O.B. __/__/____

Gender: _____ Grade: _____ ID #: _____ (optional)

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive 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 records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student living? (Please check one box.)

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

Print name of Parent, Guardian or Student
(for unaccompanied homeless youth)

Signature of Parent, Guardian or Student
(for unaccompanied homeless youth)

Date

If **ANY box other than permanent housing is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. After the student has been enrolled, the district/school must contact the previous school/district attended to request the student's educational records, including immunization records, and the enrolling district's LE liaison must help the student get any other necessary documents or immunizations.

Note to Schools/LEAS: If the student is **NOT** in permanent housing, please ensure the designation form is completed.



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Instructions For Completing the Housing Questionnaire

Purpose of the housing questionnaire

Local Educational Agencies (LEAs) are required to identify students experiencing homelessness. LEAs include school districts, charter schools and BOCES. Additionally, all LEAs that receive Title I funds must ask enrolling students about their housing status. The New York State Education Department (NYSED) encourages all LEAs regardless of whether they receive Title I funds to do the same. To collect this information, LEAs may:

1. Use the Housing Questionnaire attached here.
2. Update/modify the Model Enrollment Form- Housing Questionnaire to address the needs of the LEA, or
3. Incorporate the housing status question from the Model Enrollment Form – Residency Questionnaire into the LEAs Enrollment Form or other documents already used by the LEA during the enrollment process.

If LEA elects the third option and incorporates the housing status question into the LEAs Enrollment Form, the LEA should take steps to ensure that a student's housing status does not become part of the students' permanent record, because of the sensitive nature of this information. Please see the section titled "Confidentiality" (below) for information about how and when housing information may be shared within the LEA.

Who should fill out the Housing Questionnaire?

A Housing Questionnaire should be filled out for all students enrolling in school and for all students who have a change of address in grades preschool-12. "Preschool" includes any LEA administered or funded school program, such as Pre-K or Head Start Program administered by an LEA. The Housing Questionnaire should be completed by the student's parent, person in parental relation, or in the case of an unaccompanied youth, by the student directly.

Confidentiality

Student Housing information should be kept confidential to the maximum extent possible. This information should only be shared with LEA/school staff members who need information about housing status to ensure that the students' educational needs are met.

To this end, LEAs may share a student's Housing Questionnaire with LEA personnel such as:

1. The LEA liaison
2. The registrar
3. The student's teachers, and/or guidance counselor, and
4. The LEA staff member responsible for reporting data to SED

However, this information should only be shared with the above staff members to the extent that it will enable them to better meet the educational needs of the students in question and to fulfill reporting requirements mandated by SED.

Other than the above uses, housing information should be kept confidential and should not be shared with other LEA/school personnel due to its sensitivity nature and the stigma attached to being labeled homeless. LEAs are also encouraged to seek out ways of preventing housing questionnaires and housing information from becoming a part of a student's permanent record.

Discussing the Housing Questionnaire with Students and Families

In reviewing the housing questionnaire with parents, persons in parental relation, and unaccompanied youth, LEAs should emphasize the purpose of gathering information is to ensure that students in temporary housing arrangements are provided with the rights and services to which they are entitled under the McKinney-Vento Act. These rights and services include:

1. The right to stay in the same school the student had been attending before losing his/ her housing or the last school attended (both known as the school of origin),
2. The right to immediate enrollment for students who decide to transfer schools, even if the student does not have all the documents normally for enrollment,
3. Transportation services if the student continues to attend the school of origin,
4. Categorical eligibility for Title I services if offered in the LEA,
5. Categorical eligibility for free meals if offered in the LEA, and
6. Access to services provided with McKinney-Vento funds if available in the LEA.



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New Student Enrollment

Welcome to our school community! Please complete the sections below to help us ensure a smooth transition for your student.

Section 1: Previous School History

Information in this section allows us to request official transcripts and records.

- Last School Attended: _____
- School Address: _____
- City/State/Zip: _____
- Phone Number: _____ Fax Number: _____

Section 2: Student Information

Please provide legal documentation (birth certificate and social security card) to verify these details.

- Student Full Name: _____
- Social Security Number _____ - _____ - _____
- Date of Birth: _____ Place of Birth: _____
- Grade Entering: _____

Section 3: Parent/Guardian Information

(If separated or divorced, please provide custody documentation and any court ordered child contact restrictions)

- Parent/Guardian (1) Name: _____
- Highest Level of Education Completed: _____
- Home Address: _____
- Mailing Address: _____
- (H) Phone: _____ (C) Phone: _____ (W) Phone: _____



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- **Parent/Guardian (2) Name:** _____
- **Highest Level of Education Completed:** _____
- **Home Address:** _____
- **Mailing Address:** _____
- **(H) Phone:** _____ **(C) Phone:** _____ **(W) Phone:** _____
- **Military Status:** Is a parent or legal guardian currently active in the military?
[] No
[] Yes (If yes please provide documentation of current military orders/address)

Section 4: Academic Support

This information helps us provide the necessary resources for your child's success.

- **Academic History:** Has your child ever repeated a grade?
[] No [] Yes (If yes which grade?) _____
- **Educational Services:** Does your child currently receive any of the following? (Check all that apply):
 - [] IEP (Individualized Education Program)
 - [] 504 Plan
 - [] AIS (Academic Intervention Services)
 - [] Other extra help/support services

Certification: *I certify that the information provided on this form is true and accurate to the best of my knowledge.*

Signature of Parent/Guardian: _____ **Date:** _____



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Emergency Contact & Medical Information

Please complete this form accurately and notify the main office immediately of any changes to contact information to ensure your child receives the best care possible in the event of an emergency.

Student Information

Student Full Name: _____

Grade Level: _____ Date of Birth (MM/DD/YYYY): _____

Parent/Guardian Name(s):

Primary Phone: _____ Secondary Phone: _____

Parent/Guardian Name(s):

Primary Phone: _____ Secondary Phone: _____

Emergency Contacts

In the event of an emergency, if a parent or guardian cannot be reached, please contact the following individuals in the order listed:

	<i>Name</i>	<i>Relationship to student</i>	<i>Contact number</i>
1.	_____	_____	_____
2.	_____	_____	_____

Turn over to complete →



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3. _____

4. _____

Medical & Healthcare Provider:

- Physician's Name: _____ Phone: _____
- Preferred Hospital: _____

Known Allergies (Food, Medication, Environmental):

Current Medications:

Emergency Consent & Authorization

In the case of an accident or serious illness, I request the school contact the physician listed above. If the physician cannot be reached, I hereby give the school permission to make any arrangements deemed necessary for the safety and well-being of my child, including the administration of first aid and transportation to the nearest medical facility.

Parent/Guardian Signature: _____ **Date:** _____



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Authorization for Release of Student Records

- Student Full Name: _____
- Date of Birth: _____ Grade Level: _____
- Previous School Name: _____
- Previous School City/State: _____
- Previous School end date of enrollment: __/__/__

Parent/Guardian Signature: _____ Date: __/__/__

The student named above is transferring to Crown Point Central School. To ensure proper placement and continuity of educational services, we request the transfer of all pertinent records.

Please provide a comprehensive student file, including but not limited to:

- **Academic Records:** Official transcripts, latest report card, and standardized test scores and all lab report scores for Regents Science Classes.
- **Special Services:** Individualized Education Programs (IEP), 504 Plans, and recent psychological or educational evaluations. If you use **IEP Direct**, please transfer student's special education documents to us electronically to the **attention of Tieah Gunnison, CPSE Chairperson.**
- **Health Records:** Immunization records and current physical examination reports.
- **Attendance & Discipline:** Attendance history and any relevant disciplinary records.
- **Administration:** Copies of birth certificate and social security card.

Please transmit the requested records to **Crown Point Central School** using one of the following methods:

- **By Email:** mainoffice@cpcsteam.org
- **By Mail:** Crown Point Central School Attn: Student Enrollment/Main Office Secretary
P.O. Box 35, 2758 Main Street Crown Point, NY 12928
- **By Fax:** 518-597-4121



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Tara S. Celotti Superintendent tara.celotti@cpcsteam.org	Shari L. Brannock Asst. Superintendent for Business brannock@cpcsteam.org	Victoria D. Russell District Treasurer vrussell@cpcsteam.org
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Caleb Spaulding- Transportation Supervisor
518-597-4208

Transportation Request

Name of Student: _____
Last First, Middle

Street Address: _____

Town, State, Zip: _____

Phone: _____
Home Work Cell

Print/Parent or Guardian **Signature/Parent or Guardian**

Additional Information:



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Student Racial and Ethnic Identification

To Parent(s)/ Guardians:

The Crown Point Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Crown Point Central School District in accordance with the federal categories and definitions. The information will be used as:

- Report information to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

We need your help to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check in the box for the category or categories which best describe your child. The Crown Point Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Confidentiality Procedures and Regulations

To School Staff:

This form will be filed in the students' permanent record as confidential information.

To Parent(s)/Guardian:

The information which you have provided on this form is confidential. It is protected by the confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

Please complete the form on the back



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Student Racial and Ethnic Identification Form

Student Name: _____

Date of Birth: ___/___/___ **Student ID:** _____

School: _____ **Grade:** _____

Instructions: The U.S. Department of Education requires schools to collect and report student race and ethnicity data. This information is confidential and used for federal reporting, funding, and ensuring equal educational opportunities.

Please answer **both** Question 1 and Question 2.

Part 1: Ethnicity

Is the student Hispanic, Latino, or of Spanish origin?

(Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Yes - Hispanic/Latino

No - Not Hispanic/Latino

Part 2: Race

Select one or more races from the following five categories:

(Select all that apply, regardless of your answer to Part 1.)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Signature of Parent/Guardian _____

Date _____



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**Information about Special Education upon entry to school
Chapter 434 of the Laws of 2014**

Statute: Section 4402
Effective Date: July 1, 2015

Dear Parent/Guardian:

School districts are now required to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of Special Education services or programs upon their entry into public school. Please find the statute below. A parent's guide to special Education can be found on the New York State Education department's website at WWW.NYSED.GOV. This guide is available in both English and Spanish.

Statute: Chapter 434 of the Laws of 2014

Section 1. Section 4402 of the Education Law is amended by adding a new *Subdivision 8* to read as follows:

Subdivision 8. Upon their child's enrollment or attendance in a public school, such school shall notify every parent or person in parental relation of their rights regarding referral and evaluation of their child for the purposes of Special Education services or programs pursuant to applicable federal and state laws. Such notification may be provided by directing parents or persons in parental relation to obtain information located on the department's website relating to *A Parent's Guide to Special Education* in New York for children ages three through twenty-one provided the notification shall also contain the name and contact information for the chairperson of the school district's committee on Special Education or other individual who is charged with processing referrals to the Committee in the district.

Section 2. This act shall take effect July 1, 2015. Effective immediately, the addition, amendment and/or repeal of any rules or regulations necessary for the implementation of this act on its effective date are authorized to be made on or before such date,

If you have any questions, please contact our

CSE Chairperson, Tieah Gunnison
@ tgunnison@cpcsteam.org
or 518-597-3285



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Internet Permission Slip

If you wish to allow your child access to the district's computer network and the internet, please sign and return this form. Failure to return this form will result in your child being denied access to the Crown Point School Network and Internet.

As the parent of legal guardian of _____,
I grant my son or daughter to access networked computer services such as Internet. I understand that individuals and families may be held liable for violations. I understand that some materials on the Internet may be objectionable, but I accept responsibility for guidance of Internet use-setting and conveying standards for my daughter or son to follow when selecting, sharing, or exploring information and media.

Parent / Guardian Signature

Date

Student Agreement Form

As a user of the Crown Point Central School computer network, I hereby agree to comply with the above stated rules, communicating over the network in a reliable fashion, while honoring all relevant laws and restrictions. I understand that some materials on the Internet may be objectionable and are inappropriate and unacceptable for use in a school environment. I accept responsibility for Internet use when selecting, sharing or exploring information and media.

Student Signature

Date

E-Mail Permission Form

I give my child _____, permission to have a school-based e-mail based upon the Student E-Mail System Policy on page 70 & 71 in the Student Handbook.

Parent / Guardian Signature

Date



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Walking Field Trip Permission Slip

By signing this permission slip, your child can accompany the class on such trips, and a separate permission slip will not be necessary each time.

My child, _____, has my permission to participate in any field trips that occur within walking distance of the Crown point Central School.

Parent/Guardian: _____ Date: _____



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PHOTO/VIDEO MEDIA RELEASE OPT-OUT FORM

Photographs and/or videos of your child at school or school-sponsored events and extracurricular programs may be taken by school employees or by other individuals at the request of the school. Crown Point Central School shares publications such as newsletters and maintains a website and social media sites, parentsquare & a CPCS Facebook, where we share photographs and information about the school and our students' achievements and activities.

***NOTE:** School officials cannot prevent the media or community organizations from photographing or interviewing students off school property which may occur for certain sporting events, school plays, concerts or other public events.*

If you authorize Crown Point Central School to use your child's image or likeness and name as described above, nothing is required of you.

If you wish to DENY PERMISSION for the inclusion of your child's image or likeness in media, including school-sponsored social media accounts, the school district website, partner publications, or school district publications, please complete the required section below and submit it to info@cpcsteam.org or mainoffice@cpcsteam.org. You should receive confirmation that your form was received.



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**Opt-Out of Photographs/Videos
For School Year 2025- 2026**

I am the parent or guardian of the below student and I do **not** consent to the use of my child's image or likeness in media, including school-sponsored social media accounts, the school district website, partner publications, or school district publications.

Name of Student:

School:

 CPCS

Parent/Guardian Name:

Parent/Guardian Signature:

Additionally, I do not wish to have my child's photograph in the yearbook.

Parent/Guardian Signature:

If you opt out now and change your mind later, you may opt back in by contacting:

Lori Cutting in the Main Office



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Home Language Survey

Student Name: _____ Date of Birth: _____ Grade: _____

Purpose of this Survey: The information provided below helps our school provide the best possible education for your child. Understanding how well your child **understands, reads, and writes English** allows us to provide the most effective and personalized education possible to ensure their academic success.

- What language(s) is spoken in the student's home or residence?
 English Other _____
- What language(s) is spoken most of the time to the student, in home or residence?
 English Other _____
- What language(s) does the student understand?
 English Other _____
- What language(s) does the student speak?
 English Other _____
- What language(s) does the student read?
 English Other _____
- What language(s) does the student write?
 English Other _____

In your opinion, how well does the student understand, speak, read and write English?

Understands English very well only a little Not at all

Speaks English very well only a little Not at all

Reads English very well only a little Not at all

Writes English very well only a little Not at all

Signature of Parent / Guardian: _____ Date: _____



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Parent Portal
Monitor Your Child's Academic Progress Online

Dear parents or Guardians:

Our school uses *SchoolTool*, a student management system for report cards, attendance, discipline, etc. The *SchoolTool* Parent Portal is one of the many ways to keep in touch with your child's academic progress. It is available to all parents in the Crown Point Central School District for students in grades 6-12. The Parent Portal is a component of the *SchoolTool* student information system and allows parents and/or legal guardians to view their child's class schedule, grades, assignments, attendance record, and discipline history and contact information from any device that can access the internet.

If you are interested in using the parent portal, please go online to cpcsteam.org and complete the online registration form located under the Parent Portal Tab. Once the form is submitted to the office you will receive an email with information about logging in and creating an account as well as some basic information about how to use the portal and find information.

On the back of this letter is information about what to do once you have received a username and password

If you submit the registration form, please keep this letter to guide you through the portal.

Please contact the school office with any questions.

Lori Cutting
School Secretary





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SchoolTool- what you will see/how to use

From the Crown Point Central School Home page- cpcsteam.org

Tab over to Parents

Click on Parent Portal Request Form

Complete Form and hit Send

You will receive a password.

After you log-in

You will see your child's name/address.

Click on the purple triangle to the left of your child's name.

Under your child's contact information

In green you will see what class your child is in at the current time, if you are checking between 8AM and 2:25PM.

Below your child's contact information are tabs for Contacts, Schedule, Attendance, Discipline, Grades, Assessments, Assignments and Letters.

- **CONTACTS-** shows you all of the contact information that you provided to the school.
- **SCHEDULE-** shows your child's schedule. Next to the teacher's name is an email icon you can click on to email that teacher.
- **ATTENDANCE-** shows your child's attendance by day or by class.
- **DISCIPLINE-** shows any discipline reports on your child.
- **GRADES-** shows your child's grades. The view drop down box allows you to see the marking period grades, progress report grades or the marking period averages.
- **ASSESSMENTS-** shows your child's state test scores on the 3-8 math and ELA exams.
- **ASSIGNMENTS-** shows your child's assignments and grades that have been entered into each teacher's grade book.
- **LETTERS-** shows any letters that have been sent home regarding your child.



2758 Main Street P.O. Box 35 Crown Point, New York 12928
Phone 518-597-3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Dear Parents, Guardians and School Staff;

NYS Education law Section 409-H, effective July 1, 2001, requires all public and non-public elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The following pesticide application(s) took place:

Date of Application	Location of Application	Product Used
NONE		

As a reminder, Crown Point Central School is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are not subject to prior notification requirement.

- The school remains unoccupied for a continuous 72 hours following the application of a pesticide that would otherwise dictate the use of a 48-hour notification.
- Anti-microbial products; non-volatile rodenticides in tamper-resistant bait stations in areas inaccessible to children.
- Non-volatile insecticidal baits in tamper-resistant bait stations in areas inaccessible to children.
- Silica gels and other non-volatile, ready-to use pastes, foams, or gels in areas accessible to children.
- Boric acid and disodium octaborate tetra hydrate.
- The application of EPA designated exempt materials under 40CFR152.25.
- The use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, God Faith effort will be made to supply written notification to those on the 48-hour Prior Notification List. If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in our school buildings, please complete the enclosed form and return it to Caleb Spaulding, IPM coordinator, Crown Point Central School, PO Box 35, Crown Point, NY 12928

Please feel free to contact me at 518-597-3285 for further information on these requirements.

Sincerely,

Caleb Spaulding, CPCS IPM Coordinator

CS/lmc
Cc;Tara S. Celotti, Superintendent of Schools





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Request for Pesticide Application Notification

Please Print

(Name)

(Address)

(Town, State, Zip code)

(Day Phone)

(Evening Phone)

(E-mail Address)

Community Eligibility Provision (CEP)/Provision 2 non-base year Household Income Eligibility Form

_____ (name/school) is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete only one form for your household, sign your name and return it to the school named above. Call _____ (school phone number), if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. SNAP/TANF/FDPIR Benefits: _____
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Then skip to Part 4.

Name: _____ CASE #: _____

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions Amount / How Often	Child Support, Alimony Amount / How Often	Pensions, Retirement Payments Amount / How Often	Other Income, Social Security Amount / How Often	No Income
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: _____ Date: _____

Email Address: _____
Home Phone _____
Work Phone _____
Home Address _____

SNAP/TANF/Foster Income _____
Total Household Income/How Often: _____
Free Eligibility _____
Reduced Eligibility _____
Denied Eligibility _____
Household Size: _____

DO NOT WRITE BELOW THIS LINE -- FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

CEPI/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1

ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.

- (1) Print the names of the children, including foster children, for whom you are applying on one form.
- (2) List their grade and school.
- (3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2

HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

- (1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
- (2) An adult household member must sign the form in PART 4. **SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4

ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
- (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly.** If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.

PRIVACY ACT STATEMENT

Insert your LEA's privacy policy statement here.

The Privacy Act of 1974, as amended, 5 U.S.C. § 552a, establishes a code of fair information practices that governs the collection, maintenance, use, and dissemination of information about individuals that is maintained in systems of records by federal agencies. A system of records is a group of records under the control of an agency from which information is retrieved by the name of the individual or by some identifier assigned to the individual. The Privacy Act prohibits the disclosure of a record about an individual from a system of records absent the written consent of the individual, unless the disclosure is pursuant to one of twelve statutory exceptions. The Act also provides individuals with a means by which to seek access to and amendment of their records and sets forth various agency record-keeping requirements.

Crown Point Central School

Meal Charge and Prohibition Against Meal Shaming Policy

I. Purpose

The goal of the *Crown Point Central School* is to provide student access to nutritious no- or low-cost meals each school day and to ensure that a pupil whose parent/guardian has unpaid school meal fees is not shamed or treated differently than a pupil whose parent/guardian does not have unpaid meal fees.

Unpaid charges place a large financial burden on our school. The purpose of this policy is to insure compliance with federal requirements for the USDA Child Nutrition Program and, and to provide oversight and accountability for the collection of outstanding student meal balances to ensure that the student is not stigmatized, distressed or embarrassed.

The intent of this policy is to establish procedures to address unpaid meal charges throughout the *Crown Point Central School* in a way that does not stigmatize, distress or embarrass students. The provisions of this policy pertain to regular priced reimbursable school breakfast, lunch and snack meals only. The *Crown Point Central School* provides this policy as a courtesy to those students in the event that they forget or lose their money. Charging of items outside of the reimbursable meals (a la carte items, adult meals, etc.) is expressly prohibited.

II. Policy

Free Meal Benefit - Free eligible students will be allowed to receive a free breakfast and lunch meal of their choice each day. A la carte items or other similar items must be paid/prepaid.

Reduced Meal Benefit - Reduced eligible students will be allowed to receive a breakfast and a lunch meal of their choice at no charge. A la carte items or other similar items must be paid/prepaid.

Full Pay Students - Students will pay for meals at the school's published paid meal rate each day. The charge meals offered to students will be reimbursable meals available to all students, unless the student's parent or guardian has specifically provided written permission to the school to withhold a meal. A la carte items or other similar items must be paid/prepaid.

ONGOING STAFF TRAINING:

- Staff will be trained annually and throughout the year as needed on the procedures for managing meal charges using the NYSED Webinar or the school's training program.
- Staff training includes ongoing eligibility certification for free or reduced-price meals.

PARENT NOTIFICATION:

- Parents/guardians will be notified that a student's account balance is exhausted and has accrued meal charges at the end of each month and every month ending thereafter until charges are paid.

PARENT OUTREACH:

- Staff will communicate with parents/guardians with five or more meal charges to determine eligibility for free or reduced-price meals.
- School staff will make two documented attempts to reach out to parents/guardians to complete a meal application in addition to the application and instructions provided in the school enrollment packet.
- School staff will contact the parent/guardian to offer assistance with completion of meal application to determine if there are other issues within the household causing the child to have insufficient funds, offering any other assistance that is appropriate.

MINIMIZING STUDENT DISTRESS:

- School will not publicly identify or stigmatize any student on the line or discuss any outstanding meal debt in the presence of any other students.
- Students who incur meal charges will not be required to wear a wristband or handstamp, or to do chores or work to pay for meals.
- Schools will not throw away a meal after it has been served because of the student's inability to pay for the meal or because of previous meal charges.
- Schools will not take any action directed at a pupil to collect unpaid school meal fees.
- Schools will deal directly with parents/guardians regarding unpaid school meal fees.

ONGOING ELIGIBILITY CERTIFICATION:

- School staff will conduct direct certification with NYSSIS or using NYSED Roster Upload to maximize free eligibility. NYSED provides updated direct certification data monthly.
- School staff will provide parents/guardians with free and reduced-price application and instructions at the beginning of each school year in school enrollment packet.
- Schools using electronic meal application will provide an explanation of the process in the school enrollment packet and instructions on how to request a paper application at no cost.
- Schools will provide at least two additional free and reduced-price applications throughout the school year to families identified as owing meal charges.
- Schools will use administrative prerogative judiciously, only after using exhaustive efforts to obtain a completed application from the parent/guardian only with available information on family size and income that falls within approvable guidelines.
- Schools will coordinate with the foster, homeless, migrant, runaway coordinators to certify eligible students. School liaisons required for homeless, foster, and migrant students shall coordinate with the nutrition department to make sure such students receive free school meals, in accordance with federal law.

Students/Parents/Guardians may pay for meals with cash or a check payable to ***Crown Point Central School***. Funds should be maintained in accounts to minimize the possibility that a child may be without meal money on any given day. Any remaining funds for a particular student will be carried over to the next school year.

Refunds for withdrawn and graduating students; a written or e-mailed request for a refund of any money remaining in their account must be submitted. Students who are graduating at the end of the year will be given the option to transfer to a sibling's account with a written request.

Unclaimed Funds must be requested within one school year. Unclaimed funds will then become the property of the ***Crown Point Central School*** Food Service Program.

Adopted by BOE: January 23, 2024

Digital Equity Survey

To the Parent/Guardian of CPCS Student/s:

Collecting accurate data regarding digital resource access for our New York students will greatly help educators to better serve their students and families. In order to accomplish this, the New York State Education Department is asking parents or guardians to complete a Digital Equity survey (for one student in the family) in grades Kindergarten – Grade12. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, **please answer each question below** and follow any additional instructions provided for submitting or returning the survey.

Thank you for your time and cooperation.

Question 1: Did the school district issue your child a dedicated school or district-owned device for their use during the school year?

Responses: YES NO

Question 2: What is the device your child uses **most often** to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)

Responses: DESKTOP LAPTOP TABLET CHROMEBOOK SMARTPHONE
NO DEVICE

Question 3: Who is the provider of the primary learning device identified in question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)

Responses: SCHOOL PERSONAL NO DEVICE

Question 4: Is the primary learning device (identified in question 2) shared with anyone else in the household?

Responses: SHARED NOT SHARED NO DEVICE

Question 5: Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school?

Responses: YES NO

Question 6: Is your child able to access the internet in their primary place of residence?

Responses: YES NO

Question 7: What is the primary type of internet service used in your child's primary place of residence?

Responses: RESIDENTIAL BROADBAND CELLULAR MOBILE
HOTSPOT COMMUNITY WIFI SATELLITE DIAL UP
DSL OTHER NONE

Question 8: In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?

Responses: YES NO

Question 9: What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

Responses: AVAILABILITY COST NONE OTHER

This data is collected yearly for state reporting. Your time and attention to this matter are greatly appreciated as it is mandated for us to report.

NYSPHSAA TRANSFER NOTIFICATION



This form must be completed for all transfer students requesting a waiver or exemption

THE STUDENT CANNOT PARTICIPATE IN A CONTEST/SCRIMMAGE UNTIL APPROVED BY THE SECTION.

Please check one: (Required supporting documentation must be attached)

Waiver Request

Health & Safety: Appeals are considered for safety, mental health, personal relationships and other similar circumstances. Written documentation is required from Superintendent of Schools or High School Principal of the sending school indicating the specific circumstances which necessitated the transfer. Supporting documentation from a third party outside of the school may be submitted (ex. police report).

District of Residency: (No change of residence. School registration change only.) Student is returning to a school within the district boundaries of his/her residence.

Hardship: Each school shall have the opportunity to petition the section involved to approve transfer without penalty based on an undue hardship for the student. Educational Waivers will not be considered as an undue hardship.

Financial: Requires documented proof of a significant loss of income or a significant increase in expenses.

Exemption Request

Divorced/Legally Separated Parents: A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six months. The legal separation agreement must address custody, child support, spouses support and distribution of assets and be filed with the County Clerk or Issued by a Judge.

Homeless: Student declared homeless by the Superintendent under McKinney-Vento Legislation [NYSED 100.2].

Other: Exemptions (s/x) as denoted in NYSPHSAA Rule #31 (Transfer). Exemption: _____

Residency Change

NYSPHSAA transfer/residency policy states: (A residency is changed when one is abandoned and another one established through action and intent. Residency requires one's physical presence as an inhabitant and the intent to remain indefinitely. The mere renting of property within the District does not confer residency. **The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA regulations.**

By signing this document, I attest the information provided is accurate and correct; I have understanding the falsification of information could lead to ineligibility; the immediate family will be physically residing at the current address as inhabitants and intend to remain indefinitely; the student has transferred without inducement or recruitment.

Parent Signature: _____ Name (Print): _____ Date: ____-____-____

PART ONE

TO BE COMPLETED BY STUDENT'S RECEIVING SCHOOL

Receiving School: _____ Student's Name: _____

Date of Transfer: ____-____-____ Date of Birth: ____-____-____ Grade Level: _____ Date Entered 9th Grade: ____-____-____

Student/Family Previous Address: _____

Student/Family Present Address: _____

Parent's Names and Current Address(es)

(Parent I name & address): _____

(Parent II name & address): _____

Name of Sending School _____ Did student participate in athletics at sending school? Yes ___ No ___

The receiving school's administration is responsible for abiding by all NYSPHSAA Eligibility standards.

Athletic Director's signature: _____ Date ____-____-____

Principal's signature: _____ Date ____-____-____

Superintendent's signature: _____ Date ____-____-____

**** DO NOT COMPLETE BELOW - SECTION USE ONLY ****

SECTION APPROVAL: _____ SECTION EXECUTIVE DIRECTOR: _____

SECTION DENIAL: _____ DATE: ____-____-____

PART TWO

**TO BE COMPLETED BY SCHOOL STUDENT PREVIOUSLY ATTENDED
AND RETURNED TO STUDENT'S PRESENT SCHOOL**

Name of Student: _____ Date entered 9th grade ___-___-___

Did student repeat any grades? _____ If yes, which grade(s)? _____

Name of School(s) Attended Prior to Transfer _____

Date of entrance to this school _____ Date of withdrawal from this school ___-___-___

Student's address while attending the above school _____

With whom did student reside at this address (name)? _____

Relationship of this (these) person(s)? _____

PART THREE

TRANSFER STUDENT SPORT HISTORY
(Please include all sports student participated)

YEAR	SPORT	LEVEL	SCHOOL
7 th Grade	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
8 th Grade	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
9 th Grade	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
10 th Grade	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
11 th Grade	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
12 th Grade	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____
	_____	V ___ JV ___ FR ___ MOD ___	_____

The undersigned has no knowledge the student named has transferred to his/her present school without inducement or recruitment.

Athletic Director's signature: _____

Date ___-___-___

Principal's signature: _____

Date ___-___-___

Superintendent's signature: _____

Date ___-___-___



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Victoria D. Russell
District Treasurer
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Health Department
Callie Ott, RN

Dear Parent/Guardian,

Your child is about to start his/her first year at Crown Point Central School. NYS has requirements that must be completed for school entrance. Students who have not met these requirements will not be permitted to start school.

NYS Requirements:

- Physical Exam completed by your physician (Cannot be greater than 1 year old)
- Copy of immunization record (Immunization Requirements enclosed)
- Copy of Birth Certificate
- Copy of Social Security Card

A Health Office packet is enclosed. Please fill out and sign all forms and return at your pre-registration appointment time. The forms include:

- Health Survey
- School Entry Questionnaire
- Allergy Information
- Hearing/Vision Questionnaire

Thank you for your time and effort gathering this important information and I look forward to meeting you.

Sincerely,

Callie Ott, RN
School Nurse



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Health Services Provided

I would like to take this opportunity to explain the school health services provided here at Crown Point central School, and New York State Regulations. The Personal Emergency Form you filled out in the enrollment papers is a very important document for your child. If your child has special needs, please inform the school nurse. Examples of such are asthma, bee sting allergies, food allergies or a need for medication in school.

PERSONL EMERGENCY FORM: More and more parents are away from home during the day, and it is essential for the protection of our students to be able to reach someone in case an emergency or illness arises. Please list all contact numbers for yourselves and consider the availability of the other contact people you are listing.

HEAD LICE: Screenings randomly done throughout the year. Most common in the Spring and Fall season and can be easily tereate4d with over-the-counter products. Crown Point Central School has a no nit policy. No students will be allowed in school until cleared by the school nurse. Please note the enclosure on head lice.

ACCIDENTS IN SCHOOL: If a student is injured in school, the parent/guardian is notified. The student will be treated with appropriate first aid measures until the person in parental authority can authorize further treatment. Crown Point central School maintains a student accident insurance policy that is non-duplicating. If an accident occurs during school or a school sponsored activity, this policy will pay claims in excess of any other coverage you may have on your child up to the usual reasonable expenses as determined by the insurance carrier.

IMMUNIZATIONS: All students in New York State are required to be properly immunized for school entrance and attendance. Information enclosed.

See back →



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SCHOOL PHYSICALS: School physicals are required yearly for grades K, 2, 4, 7, 10 and on all new students before entering school. Sports physicals, physicals for participation in school sports may be scheduled at any time during the calendar year. The physical is valid for a period of 12 months.

DISTANCE VISION SCREENING: Is completed yearly on students in Pre-K, K, 1, 2, 3, 5, 7 and 10th grade. The purpose of a school vision screening program is to identify students with visual impairments. Visual problems can and do affect the physical, intellectual, social and emotional development of children. Early detection of vision problems will provide a child more opportunity for educational success.

HEARING SCREENING: Must be administered to all students within 6 months of admission to the school and in Pre-K, K, 1, 3, 5, 7, and 10th grade.



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callie.ott@cpcsteam.org

Dear Parent/Guardian:

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

Vision

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

Hearing

- Screening for all newly entering students and students in Kindergarten, Grades 1, 3, 5, 7, and 10.

Scoliosis

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

Health Appraisals

- A physical examination including Body Mass Index and Weight Status Category Information is required for all newly entering students and students in Kindergarten, Grades 2, 4, 7 and 10.

Dental Certificates

- A dental certificate is requested for all newly entering students and students in Kindergarten, Grades 2, 4, 7 and 10.

A letter will be sent home if there are any findings in the screening done at school that would cause concern or need medical follow-up. Please call the school's Health Office if you have any questions or concerns.

2025-26 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "[ACIP-Recommended Child and Adolescent Immunization Schedule](#)." Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³		Not applicable		1 dose given after age 10 years
Polio vaccine (IPV/OPV) ⁴	3 doses		4 doses or 3 doses if the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose		2 doses	
Hepatitis B vaccine ⁶	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart and between the ages of 11 years through 15 years	
Varicella (Chickenpox) vaccine ⁷	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses			Not applicable
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses			Not applicable

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months, 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
 - d. [For further information, refer to the the CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age.](#)
 - e. [For further information, refer to the the CDC Catch-Up Guidance for Children 7 through 9 Years of Age.](#)
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 12: 7 years).
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
 - d. [For further information, refer to the CDC Catch-Up Guidance for Children 10 through 18 Years of Age.](#)
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months, 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses that are each separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.
 - e. [For further information, refer to the CDC Catch-Up Guidance for Children 4 Months through 17 Years of Age.](#)
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (pre-kindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 12: 10 years).
 - a. One dose of meningococcal conjugate vaccine is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
 - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months*. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)

*Depending on vaccine brand, schedule may change.

For further information, contact:

New York State Department of Health
Division of Vaccine Excellence
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
School Compliance Unit, Bureau of Immunization
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

05/25



2758 Main Street P.O. Box 35 Crown Point, New York 12928
Phone 518-597-3285 Fax 518-597-4121

Tara S. Celotti
Superintendent
tara.celotti@cpcsteam.org

Shari L. Brannock
Asst. Superintendent for Business
brannock@cpcsteam.org

Victoria D. Russell
District Treasurer
vrussell@cpcsteam.org

Health Department
Callie Ott, RN
518-597-3285
callie.ott@cpcsteam.org

School Entry Questionnaire

No one knows a child better than their parents or guardian. Please answer the questions below so we may gain more insight concerning your child.

Student Name: _____ Date of Birth: _____

Address: _____

Name of Pre-School: _____ Dates Attended: _____

Fathers Name: _____

Address: _____

Phone Number: (H) _____ (C) _____ (W) _____

Occupation: _____ Work Location: _____

Education: Circle the highest grade completed: Grade 9, 10, 11, 12 College: 1, 2, 3, 4

Mother's Name: _____

Address: _____

Phone Number: (H) _____ (C) _____ (W) _____

Occupation: _____ Work Location: _____

Education: Circle highest grade completed: Grade 9, 10, 11, 12 College: 1, 2, 3, 4

Siblings:
Name: _____ Age _____ Name: _____ Age: _____

Name: _____ Age _____ Name: _____ Age: _____

Name: _____ Age _____ Name: _____ Age: _____

Parents Marital Status:
Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

*If parents are separated or divorced, Parent with legal custody is _____
(Continued on back) -->



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Do you have any legal documents for us to follow? Yes ___ No ___ (Please provide a copy)

Is there anyone forbidden to pick up your child? _____

Who is directly responsible for your child if the parents work? _____

Name & telephone number of person to notify in case of emergency, if neither parent can be reached. Name _____ Number _____

In case of an emergency, do you authorize the school officials to use their best judgement in aiding your child? Yes ___ No ___

Has your child ever had a seizure? Yes ___ No ___

Information: _____

How does your child feel about starting school? _____

Is your child easily disciplined (does he/she accept direction)? Yes ___ No ___

How do you discipline? _____

Is it effective? Yes ___ No ___

In your opinion, does your child need help in any specific area? (Speech, Social Relationships, Small or Large Muscle Coordination, etc.) Yes ___ No ___ Please comment.

Additional information you wish to share.



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Health Survey

Student's Name: _____ Sex: _____ DOB: _____
Primary Care Provider: _____ Phone Number: _____
Address: _____ Date of last exam: _____

Has your child had: (Please give dates and pertinent information)

____ Repeated illnesses: _____
____ Serious Injuries: _____
____ Surgery/Hospitalization: _____
____ Chicken Pox (Must have documentation from health care provider with date of disease.)

Does your child have: (Please give specific dates and pertinent information)

____ Any allergies: _____
____ Vision problems: _____
____ Wear Glasses _____
____ Hearing problems: _____

Will he/she need to take medication during school hours? Yes ____ No ____
(If yes, please see the school nurse for required physician's order form.)

Please comment on any health concern not mentioned above that you would like your child's teacher and school nurse to be aware of.



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Hearing Screening Questionnaire

Student's Name: _____ Sex: _____ DOB: _____

1. How many colds/sore throats does your child have every year? _____
2. Has your child had more than 2 ear infections in the past year? _____
3. Do any of his/her siblings have ear problems? _____
4. Did parents or grandparents have hearing problems as children? _____
5. Does your child respond to or communicate with people outside the family? _____
6. Does your child watch your mouth when you speak to him/her? _____
7. Does your child stand very close to the TV or to speak to you? _____
8. Does your child have trouble paying attention when you speak? _____
9. Does your child respond when you call him/her from another room? _____
10. Does your child sneeze a lot or have a stuffy nose frequently? _____
11. Does your child have discharge from his/her ears or trouble with earwax? _____
12. How do you clean your child's ears? _____
13. Do you talk to your child about not putting things in his/her ears? _____
14. How do you clean your child's ear lobes after ears are pierced? _____
15. Is there any history of allergies in your family? _____
16. Does your child have any allergies to foods, medicines, pollens, animals or anything else? _____
17. Is there cigarette smoking in your house? _____
18. Any other pertinent information, not mentioned above that you would like your child's teacher and the school nurse to be aware of? If so, please list below.



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Vision Questionnaire

Student Name : _____ **Sex :** _____ **DOB :** _____

Does your child have any of the following concerns?

1. Hold a book very close (7-8 inches away)? _____
2. Turn their head to use only one eye? _____
3. Cover or close one eye while reading? _____
4. Squint for either near or far vision tasks? _____
5. Move head back and forth, rather than eyes while reading? _____
6. Omit letters, words or phrases? _____
7. Complaint of seeing double or blurred vision? _____
8. Handwriting, which is difficult to read, crowded or inconsistent in size? _____
9. Mistakes words with similar beginnings? _____
10. Miscalls or omits small words? _____
11. Excessive blinking or watering of eyes? _____
12. Loses place while reading? _____
13. Headaches during or after reading? _____
14. Misaligns digits in columns of numbers? _____
15. Writes uphill or downhill? _____
16. Reverses letter (d for b) or words (saw for was)? _____
17. Uses a finger or marker to keep place? _____
18. Re-reading or skips words while reading? _____
19. Excessive rubbing of eyes while engaged in visual tasks? _____
20. Fatigues easily? _____
21. Lip reads or whisper reading to reinforce comprehension? _____
22. Poor eye hand coordination (difficulty catching a ball)? _____
23. Burning or itching eyes? _____
24. Any other pertinent information not mentioned above that you would like to share with your child's teacher or the school nurse. If so, please list below.



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Allergy Information

Dear Parent/Guardian;

It is important to know if your child has any allergy problems. Please be specific.
My child, _____ is/is not (circle one) allergic to bee stings.
My child has a local reaction only (at site if stung) and requires treatment as follows:

Benadryl cannot be administered without a physician's order

Medication Allergies: Please list

Food Allergies: Please list

Any medication needed to treat any allergy needs to be in the health office in accordance with the New York State Department of Health/Education Law.

- **Written parental permission to give specified medication.**
- **Doctor's written authorization to give specified medication.**
- **Medication is in its original container or package with prescription attached and delivered to the school nurse by a responsible adult.**

Parent/Guardian _____ **Date** _____

**Crown Point Central School District
Committee on Special Education
2758 Main St.
PO Box 35
Crown Point, NY 12928 (518-597-3285 x6)**

Medicaid Consent

Dear Parent or Guardian:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP).

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of, _____ have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Client Identification Number (CIN): _____

Parent/Guardian Signature: _____

Print Name: _____

Date: _____



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Medication Policy

The administration of any medication to a student during school hours will be permitted ONLY when failure to take such medication would jeopardize the health of a student. Medication will include all prescribed medication by a physician and includes over the counter medications such as Aspirin, Tylenol, cough Syrup, etc.

BEFORE ANY MEDICATION MAY BE ADMINISTERED TO A STUDENT during school hours the New York State Department of Education and Health and the Crown Point Central School Board require:

- The written consent of the parent and the physician, which will give permission for the administration of medication and relieves the board and its employees of liability
- The written consent of the physician, describing dosage, appropriate time to medicate, possible side effects, diagnosis, etc.
- The medication must be in its original container showing the original prescription with the pharmacist's label attached.

Procedures for administering medications will require

1. All medications will be brought to school by the parent/guardian or a designee appointed by the parent and personally given directly to the school nurse. The nurse will count the medication with the parent/designee and record.
2. All medications will be administered by the school nurse, the principal or his/her designee.
3. Medications will be securely stored and kept in their original labeled container, locked in the nurse's office.
4. The school nurse will maintain a record of the name of the student to whom the medication is to be administered, the prescribing physician, the dosage, time of administration and initialed by the nurse at each scheduled time.
5. All medications should be picked up at the end of the school year or at the end of the medication regime, whichever comes first. ALL MEDICATIONS NOT PICKED UP WITHIN FIVE (5) DAYS AFTER THE END OF MEDICATION PERIOD OR CLOSE OF SCHOOL WILL BE DISCARDED.



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SEVERE ALLERGY ALERT

We are committed to providing a safe and welcoming environment for all of the children in our school.

**THERE IS AT LEAST ONE CHILD IN
CROWN POINT CENTRAL SCHOOL THAT HAS A**

SEVERE FOOD ALLERGY (5-12-2021)

The food(s) that we are concerned with are:

PEANUTS, ALL NUTS, WHITE POTATO, MILK, EGG, COCONUT,
AVACADO, OAT, WHOLE WHEAT, MUSHROOMS, ALL FISH,
TUNA, PINEAPPLE, ONIONS, & ORANGES

While some allergic reactions can be mild, many students with severe food allergies experience serious, potentially life-threatening symptoms to eating (and in some cases touching and smelling) the food that they are allergic to. Please be careful not to send foods into the school that contain things that students may be allergic to.

Specific classroom with children with food allergies will receive additional information as to foods permitted and protocols to be followed.

In addition, there are designated areas in the building that will be designated as allergen free.

Please call the school's Health Office if you have any questions or concerns.



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Head Lice (Pediculus Humanus Capitis)

Students are screened for Head Lice throughout the school year by the school nurse. If a student is observed to be scratching his/her head, he/she will be sent to the nurse for evaluation.

When Head Lice or Nits are found the parents are called and the student has to go home for treatment and will not be allowed to return to school until he/she is

NIT-FREE. The student has to be evaluated by the school nurse prior to entering the classroom on return to school.

Crown Point Central School has a **NIT-FREE** Policy which means:

1. Removing all lice eggs (nits) and egg cases after treatment with a lice killing product.
2. Excluding a child with a lice infestation from school until ALL NITS HAVE BEEN REMOVED.
3. Educating the community to insure that parents understand their responsibility under the "NO-NIT policy."

The "NO-NIT" Policy encourages home screening, eliminates diagnostic confusion, prevents transmission and re-infestation, and reduces the need for subsequent treatment.

PROPER SCREENING TECHNIQUES

When screening children for nits do the screening in natural light – near a window or with a magnification lamp. Nits are good reflectors of Ultra Violet light.

Use disposable screening tools such as: wooden sticks, tongue depressors, toothpicks or cotton applicators – so that screening personnel do not have to touch the child's hair, gloves may be used.

Conduct a thorough search – lice eggs are normally laid on hair close to the scalp.



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Lead Screening
(Required)

NYS PUBLIC HEALTH LAW ARTICLE 13, TITLE 10, SECTION 1370-1376a STATES THAT:

- Prior to or within (3) three months of initial enrollment, schools are required to obtain from the pre-school child's parent or guardian, proof that the child has had a blood lead test.
- If evidence of blood lead testing has not been received within the (3) three months of initial enrollment, the parent or guardian is:
 1. To be given information about lead poisoning; and
 2. To be referred to primary health care providers or local health department.
- The child's cumulative health record must indicate either the date of the lead test screening or that information on lead poisoning referral was provided.

Though the requirements above must be completed, a student lacking proof of lead testing may not be excluded from school (unlike failure to comply with immunization requirements).



FIDELIS CARE®

Child Health Plus +
Parents + Providers =



👍
Healthy Kids!

Does Your Child Need Health Insurance?

Fidelis Care is joining with your child's school to make sure parents know that learning about quality, free or low-cost health insurance is just a call, click, or visit away.

Through the New York State-sponsored Child Health Plus (CHPlus) program, Fidelis Care provides quality, free or low-cost health insurance for children under 19.

Coverage may be FREE or as little as \$15 per child each month, based on household income.



To learn more about health insurance for your child or any family member, visit one of our convenient community offices. Visit fideliscare.org/offices to find the community office closest to you.

★ Covered Benefits include:



- Checkups and well child visits
- Immunizations
- X-rays and lab tests
- Hospital and emergency care
- Prescription drug coverage
- Vision and dental care
- Speech and hearing therapy
- And much more!



To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through NY State of Health. The Official Health Plan Marketplace. visit www.nystateofhealth.ny.gov or call 1-855-355-5777.

Fidelis Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Fidelis Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Fidelis Care 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

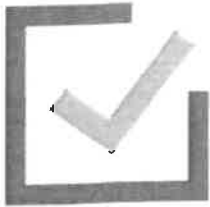
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-343-3547 (TTY: 711) 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-343-3547 (TTY: 711)

1-888-FIDELIS (1-888-343-3547) • TTY: 711



fideliscare.org

@fideliscare



Permission to Contact



FIDELIS CARE[®]

- YES!** Please have a Fidelis Care representative contact me regarding free or low-cost health insurance coverage.
- YES!** Please help me stay covered with Fidelis Care and contact me regarding questions about my recertification.

Please fill out the form below and send it to Fidelis Care one of three ways:

FAX



833-744-0455

MAIL



31 British American Blvd
Latham, NY 12110

EMAIL



albmarketing@fideliscare.org
Snap a photo and email

Name (please print): _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Telephone: Home: () _____ Cell: () _____

Email: _____ Fidelis Care Representative: **CRS: Amy Pawlowski**

What is the best time to contact you? Mornings Afternoons Evenings

What is your primary language? _____

How did you hear about Fidelis Care? (Referral source): **Crown Point Central School**

Signature: _____ Date: _____

*By completing and signing this form, I give permission for a Fidelis Care representative to contact me regarding health insurance or to renew my current coverage.

Crown Point Central School

Fidelis Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Fidelis Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Fidelis Care 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-343-3547 (TTY: 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-343-3547 (TTY: 711). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-343-3547 (TTY: 711)。

1-888-FIDELIS (1-888-343-3547) • TTY: 711

fideliscare.org

@fideliscare





IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (____) - ____ - ____ Best time to be reached: ____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program- Identification and Recruitment Office; 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: Yes Not Done Hypertension: Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:
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SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

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
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Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
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Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

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

*Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act

Student may participate in all activities without restrictions.

If Restrictions Apply – Complete the information below

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 ONLY 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

Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

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

MEDICATIONS

Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE

Confirmed free of communicable disease during exam

IMMUNIZATIONS

Record Attached Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature: _____

Provider Name: *(please print)*

Provider Address:

Phone: _____

Fax: _____

Please Return This Form to Your Child's School Health Office When Completed.

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 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 or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Sex: Male Female Will this be your child's first oral health assessment? Yes No

School: Name 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/ Dental Hygienist

I. The dental health condition of on (date of assessment) The date of the assessment 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/ Dental Hygienist's 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). 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]. Untreated Caries - Does this child have an open cavity? [At least 1/2 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]. Dental Sealants Present

Other problems (Specify): II. 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.