P.O Box 177
104 Main Street
Fillmore, NY 14735
Phone: (585) 567-2251
Fax: (585) 567-2541

FILLMORE CENTRAL SCHOOL

April 1, 2020

Dear Families;

Fillmore Central School will provide a Three-Year-Old Preschool Program for eligible students during the 2020-21 school year. Children born between December 2, 2016 and December 1, 2017, are eligible to participate in the 3PK program.

The Three-Year-Old Preschool Program is a voluntary program for parents who desire a Pre-Kindergarten experience for their children. The program

- is a half day session (8:05-11:15 or 12:15-3:13),
- follows the Fillmore Central School calendar,
- is located in the Fillmore Central School building,
- is no cost to parents,
- has a certified teacher and support staff,
- provides a developmentally appropriate curriculum focusing on cognitive, social, emotional, and physical skill development.

Unfortunately, because of additional regulations, Fillmore will not be able to provide transportation for all students in the 3-year-old preschool. The District recognizes some families are physically or legally unable to provide transportation. If your child is not attending due to an inability to provide transportation please contact Mrs. Aylor.

If you are interested in your child being a member of the 2020-21 Three-Year-Old Preschool Program, please complete and return all of the enclosed Pre-Kindergarten entrance forms. In addition, please submit a copy of your child's *immunization records* and *birth certificate*. All paperwork must be submitted before your child may enter the program.

Applications must be received by July 31, 2020. The 3-Year-Old preschool program is only permitted to service eighteen students in each session. If more than thirty-six student applications are submitted, Fillmore Central will institute a lottery system to fill the preschool openings. In District students enrolled in the 3-year-old program will have first rights to the District's UPK program for 4-year-old students the following year.

If you have any questions, please contact me at 567-4432. Thank you for your interest in our 3-year-old preschool program. We look forward to receiving your child's registration information and working with you and your child.

Sincerely,
Chelsey Aylor
Pre-K-4 Principal/ Pre-Kindergarten Coordinator

Fillmore Central School
3 Year Old Pre-Kindergarten
Entrance Checklist

Child's Name: _____ Date of Birth: _____

_____ Entrance Form

_____ Emergency Form

_____ Developmental and Social History Form

_____ Health Form

_____ Physical (completed by a physician)

_____ Home Language Questionnaire/ Identification of Homeless Students Form

_____ Immunization Records

_____ Dental Health Certificate

_____ Birth Certificate

Please return all forms and the checklist to:

Chelsey Aylor
Pre-K-4 Principal/ Pre-Kindergarten Coordinator
Fillmore Central School
104 Main Street
Fillmore, NY 14735

Office use:
Date Information Received: _____

Preschool applications must be returned before July 31, 2020

Fillmore Central School Entrance Form

Student Number: _____ Grade: 3 Year Old Pre-K Teacher: Mrs. Reed
Date Registered: _____ SSN: _____

Student Information

_____ DOB: _____ Sex: M F
Last Name First Name MI

_____ Circle: New Student Former Student Year(s) Attended: _____
Place of Birth

Ethnicity (Check): Is your child Hispanic/Latino or of "Spanish origin" ___ Yes ___ No
Please select one: ___ American Indian or Alaskan American ___ Asian ___ White/ Other
___ Black or African American ___ Native Hawaiian or Other Pacific Islander

□ District Resident □ Non-Resident □ Placed by DSS/ Agency Agency Name: _____

Address: _____ Telephone: _____

_____ Cell Phone Number: _____

Work Number: _____

Emergency Contact: _____ Emergency Number: _____

How many schools has this child attended? _____ Previous School: _____

Custodial Parent/ Guardian Information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Mailing Address _____

(If different from above): _____

The child's parents are: ___ Married ___ Single Parent ___ Divorced (Custody Papers: ___ received ___ needed)
The child is in foster care: ___

I can be contacted(check all that apply): _____ at home _____ at work _____ through e-mail at: _____

Non-Custodial Parent/ Guardian Information (The following people should receive information about the child.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Mailing Address: _____ Telephone: _____

_____

Census Information: Other Children in the Family

Pre-School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

In School Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Name: _____ M F DOB: _____

Request for Session

_____ Either session is workable with parent's schedule.

I NEED to have my child attend: _____ A.M. Session (8:18-11:15) _____ P.M. Session (12:15-3:13)

Please understand that your NEED for the morning or afternoon session will be considered, but may be difficult to arrange. Factors that will affect this decision will include equalization of class sizes between morning and afternoon sessions, scheduling of speech therapy or other services for qualified children, transportation requests and other issues. We will make an effort to honor your scheduling request.

Identification of Homeless Students

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? *Check one box:*

Section A	Section B
☐ in a shelter ☐ with more than one family in a house or apartment ☐ in a motel, car or campsite ☐ with friends or family members (other than parent/guardian) ☐ independently ***CONTINUE:*** *If you checked a box in Section A, complete #2*	☐ Choices in Section A do not apply

2. The student lives with:

☐ 1 parent
☐ 2 parents
☐ 1 parent & another adult
☐ a relative, friend(s) or other adult(s)
☐ alone with no adults
☐ an adult that is not the parent or the legal guardian

Home Language Questionnaire (HLQ) CR 154 A-14

Dear Parent or Guardian:

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

Thank You

District/ School: Fillmore Central School

Student Name Grade

Date of Birth Student Identification Number

Country of Birth/ Ancestry

Number of Years enrolled in school outside the US

Name/ Position of school personnel completing this section

Determination:
☐ Possible LEP ☐ English Proficient

(√ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ☐ English ☐ Other (specify) _____
2. What language(s) is spoken most of the time to the student, in the home or residence? ☐ English ☐ Other (specify) _____
3. What language(s) does the student understand? ☐ English ☐ Other (specify) _____
4. What language(s) does the student speak? ☐ English ☐ Other (specify) _____
5. What language(s) does the student read? ☐ English ☐ Other (specify) _____ ☐ Does Not Read
6. What language(s) does the student write? ☐ English ☐ Other (specify) _____ ☐ Does Not Write
7. In your opinion, how well does the student understand, speak, read, and write English?

	Very Well	Only a little	Not at all
Understands English	☐	☐	☐
Speaks English	☐	☐	☐
Reads English	☐	☐	☐
Writes English	☐	☐	☐

Parent/ Guardian Signature:_____ Date: _____

FILLMORE CENTRAL SCHOOL

Student Contact Information

Student Name:_____ **Grade**_____

Home Address:_____

Mailing Address:_____

Contact 1: *(resides with student)*

Name:_____ **Relationship:**_____

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

Email address:_____

Contact 2: *(resides with student)*

Name:_____ **Relationship:**_____

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

Email address:_____

Contact 3: (DOES NOT reside with student)

Name:_____ **Relationship:**_____

Home Address:_____

Mailing Address:_____

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

Email address:_____

Has Custody:_____ **Receives Mailings:**_____

Contact 4: (DOES NOT reside with student)

Name:_____ **Relationship:**_____

Home Address:_____

Mailing Address:_____

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

Email address:_____

Has Custody:_____ **Receives Mailings:**_____

Contact 5: (DOES NOT reside with student)

Name:_____ **Relationship:**_____

Home Address:_____

Mailing Address:_____

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

Email address:_____

Has Custody:_____ **Receives Mailings:**_____

Student Contact Update
2020-21

Student Name_____**Grade**_____

****Physical Conditions Possibly Needing Special Consideration**

Allergies: _____

_____

Other Conditions: _____

_____

In case of an accident or serious illness, I request the school contact me. If the school in unable to reach me, I hereby authorize the school to call the physician below and to follow his/ her instructions. If it is impossible to contact this physician, the school may make whatever arrangements that seem necessary.

_____ _____

Signature Parent/ Guardian Date

Physician Name: _____
Telephone Number: _____
Preferred Hospital: _____

****Early Dismissal Destination** In the event school closes early, my child will go to the indicated destination.

_____

Address Telephone

****Court Papers** Please indicate whether any type of court paper impacts this student (a copy of the court papers must be on file to be enforced by the school).
Are there any court papers impacting this child? ____Yes ___No
Please identify the type of court papers: _____

****Standing Order for Over-The-Counter Medication Permission Form**

I give permission for Fillmore Central School to administer the following OTC medication to my child to assist him/her to complete the school day. I understand this is for emergencies only and if my child needs the following medication on a regular basis I will fill out the OTC Medication Permission form and supply the OTC medication for my child.

- ☐ Tylenol/Acetaminophen
- ☐ Advil/Ibuprofen
- ☐ Hydrocortisone Cream
- ☐ Triple Antibiotic Cream
- ☐ Chloraseptic Throat Spray
- ☐ Tums
- ☐ Solarcaine
- ☐ Sun Screen

_____ _____

Parent/ Guardian Signature Date

****Consent to Publish Name/ Picture**

Fillmore Central School is proud of and enjoys sharing the accomplishments of students of all ages. At the same time, it is important to respect the rights of parents and guardians to not have information shared or publicized about their child. For this reason, the district is collecting parent and guardian consent to publish students' names and/ or pictures across various media.

As the parent/ guardian of _____, I am providing consent to Fillmore Central School to publish my child's picture, name, audio clips, student teaching videos, video clips and other school work in various media sources, including the school newsletter, yearbook, website, newspapers, etc.

_____ Yes ____No

_____ _____

Parent/ Guardian Signature Date

Fillmore Central School
3 Year Old Pre-Kindergarten
Developmental & Social History Form

CHILD NAME: _____ **DOB:** _____

Parents: The questions on this form are intended to provide school staff with information which will help us better understand your child's development, experiences and uniqueness. Please feel free to make additional comments in any area. Thank you.

Have you had concerns about any phase of your child's development? Yes ____ No ____

Comments: _____

_____

Has your child accomplished developmental milestones at the expected ages?
(Walking, first word, speaking in sentences, toileting, etc.) Yes ___ No ____

Comments: _____

Has your child had any persistent problems with eating, temper tantrums, sleep habits, bedwetting, wetting or soiling clothes, thumb sucking, fingernail biting? Yes ____ No ____

Please Explain: _____

Has your child had any persistent fears or worries? Yes ____ No ____

Please Explain: _____

Describe how your child relates to other children: _____

_____

Which hand does your child prefer to use for eating, coloring, etc.?
Right Hand ____ Left Hand ____ Undecided ____

Has your child been referred for any professional evaluation? (Hearing, vision, psychological, or medical specialist)
Please Explain: _____

_____

Are there any social/family situations of which we should be aware? (Recent separation, divorce, custody issue, family illness, recent loss) _____

_____

What other things would you like us to know about your child? _____

_____(over)

Please indicate your child's Pre-Kindergarten & Day Care experiences:

	Check all that apply	Approximate dates or ages of attendance	Name / Location of program
PreK			
Early Head Start 6 mo-3 yrs			
Head Start			
Private Pre-School			
Independent Home Day Care Provider			
No experiences outside of the home			

Please describe who is living in your home at this time:

____ Mother	____ Brother(s)	Ages: _____
____ Father	____ Sister(s)	Ages: _____
____ Step-Mother	____ Step/half brother(s)	Ages: _____
____ Step-Father	____ Step/half sister(s)	Ages: _____
____ Other Adult(s) _____	____ Foster Children	Ages: _____
____ Other Relative(s)_____	____ Other Children	Ages: _____

If applicable:
Joint Custody Parent Name: _____

Address:_____

Non-Custodial Parent Name: _____

Is this person to receive school notices and communications: Yes ____ No ____

If yes, address: _____

Fillmore Central School
3 Year Old Pre-Kindergarten
Health History Form - Parent

Name of Child: _____ Date of Birth: _____

Place of Birth: _____

Custodial parents/guardians: _____

Address: _____ Phone: (H) _____

_____ (w-mom) _____
(w-dad) _____

Child's Physical Health History:

1. Did your child have a medically normal pre-natal delivery and newborn history?
   Yes _____ No _____ (Explain) _____
   _____
2. Has your child experienced any loss of consciousness or seizures?
   Yes _____ No _____ (Explain) _____
   _____
3. Has your child experienced chicken pox, any serious illness, accident, head injury or concussion? Yes _____ No _____ (Explain)
   _____
   _____
4. Has your child been diagnosed with any physical abnormality or condition?
   Yes _____ No _____ (Explain) _____
   _____
5. Has your child experienced any ear or hearing problems that you have known or suspected? (including frequent ear infections at any age).
   Yes _____ No _____ (if yes, please indicate age(s) and if treated medically)
   _____
6. Has your child experienced any eye or vision problems that you have known or suspected? Yes _____ No _____ (if yes, please indicate age(s) and if treated medically) _____
7. Does your child wear corrective lenses? Glasses ____ Contact lenses _____
8. Is there anything concerning your child which the school should know in order to provide special care in the classroom or on field trips? _____
   _____

9. Has your child had dental care? Yes _____ No ____
   Most recent date seen: _____

10. Does your child suffer from any allergies? (e.g. food, medications, insects, sun, cosmetics, etc) Please Explain: _____
    _____
    Special medication, treatments: (inhalers, bee sting kit, etc.)
    _____

11. Is your child taking any regular medications? Yes ____ No _____

    Medication: _____ Dose if known _____ for condition: _____

    Medication: _____ Dose if known _____ for condition: _____

    Will the medication need to be administered in school? Yes _____ No _____

    Other comments: _____

12. Please list your child's medical professionals and locations/phone numbers.

	Name	Address	Phone
Physician			
Eye Doctor			
Dentist			
Specialist &Specialty			
Specialist &Specialty			

FILLMORE CENTRAL SCHOOL
HEALTH CERTIFICATE / APPRAISAL FORM

NYSED requires an annual physical exam for new entrants, students in Grades Pre-K, K, 2, 4, 7 and 10, working permits, and triennially for the Committee on Special Education. To be completed by your child's physician.
Please return this form to the School Nurse, PO Box 177 Fillmore, NY 14735 Phone 585-567-8584 Fax 585-567-2541

Date of Exam: ____/____/____

Name: _____ Date of Birth: ____/____/____ Gender: ☐M ☐F Grade: _____

Specify Current Diseases

☐Asthma (☐Intermittent or ☐ Persistent)
Quick relief inhaler ☐Yes ☐No
Asthma Action Plan ☐Yes ☐No
☐Type 1 Diabetes ☐Type 2 Diabetes
☐Hyperlipidemia ☐ Hypertension
☐Other:

PPD: ☐Positive ☐Negative Not Done Date: ____/____/____
Elevated Lead: ☐Yes ☐No ☐Not Done Date: ____/____/____
Dental Referral: ☐Yes ☐No ☐Not Done Date: ____/____/____

☐Allergies – See page 2 for details.

Significant Medical/Surgical Information: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Scoliosis: ☐Negative ☐Positive

Body Mass Index: _____ _____ . _____

Weight Status Category (BMI Percentile):

☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

Vision:	Right	Left	Referral
Vision – Without correction			
Vision – With correction			
Hearing:	**Right**	**Left**	**Referral**
20 db sweep screen both ears or			

☐ SYSTEM REVIEW AND EXAM ENTIRELY NORMAL

Specify any abnormalities: _____

☐See attached

☐ **Free from contagions & physically qualified for all physical education, playground & school activities.**

☐ Specify medical accommodations needed for school: _____ ☐ None

☐ Known or suspected disability: _____ ☐ Please monitor

☐ Restrictions: _____ ☐ Please monitor

Name: _____ Date of Birth: ____/____/____

Diagnosis	Medication Name	Dose	Route	Time	Self Directed*	Self Admin/ Self Carry**

***Self Directed:** I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing and effect of taking or not taking the medication.

****Self Admin/Self-Carry:** I have determined this student is consistent and responsible in taking their own medication (self-directed), and in addition, give them permission to self-carry and self-administer this medication.

To be completed by Parent/Guardian if medication is prescribed

☐ I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original OTC medication container/package with my child's name on it. I will bring the medication to the nurse's office and will not send it with my child. To request this option please sign below.

Parent/Guardian Signature _____ Date: ____/____/____

☐ Parent permission & provider consent is required for students to self-administer & self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below.

Parent/Guardian Signature _____ Date: ____/____/____

☐ **NONE** ☐ **NON LIFE-THREATINING** ☐ **LIFE-THREATENING**

Type: ☐Food ☐Insect ☐Latex ☐Medication ☐Seasonal/Environmental ☐Other:

Treatment prescribed: ☐None ☐Antihistamine ☐ Epinephrine Autoinjector

☐Immunization record attached	☐Immunizations received today:
☐Immunizations reported to NYSIIS	☐Will return on ____/____/____ to receive:
☐No immunizations received today	

Medical Provider Signature _____ Date: ____/____/____

Provider Name: (Please Print) _____ Phone#: _____

Provider Address: _____ Fax#: _____

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out section 2. Return the completed form to the school nurse as soon as possible. (Fillmore Central School, Health Office, PO Box 177, Fillmore, NY 14735)

Section 1. To be completed by Parent or Guardian (please print)

Child's Name:

Birth Date: / / (Month Day Year) | Sex: ☐ Male ☐ Female | Will this be your child's first visit to the dentist? ☐ Yes ☐ No

School: Fillmore Central School | 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

I. The Dental Health Condition of _____ **on** _____ **(date of exam) The date of the exam 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 name and address (please print or stamp) | Dentist's Signature

Optional Sections – If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ 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].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify) _____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.