SAUGERTIES CENTRAL SCHOOL DISTRICT

Call Box A, Saugerties, New York 12477 Telephone: (845) 247-6500

COUNSELING CENTER

Junior High Counseling Center
845-247-6563 fax 845-246-4322

Senior High Counseling Center
845-247-6656 fax 845-246-5823

REQUEST FOR PUPIL RECORDS

Date________________________

TO: Guidance Counselor

____

____

____

RE: ____

D.O.B.______________________________________ GRADE: ______________________

The above student is applying for enrollment in the Saugerties High School. Please fax the following to us as soon as possible for our review:

Transcript
Health Records, including immunizations
Psychological Reports
Current Report Card
Exit Grades
Schedule
Standardized Test Scores
Discipline Records
IEP, if applicable. Please send also to our Special Education Department, fax 845-246-8553.

If there are any Science Labs, please forward by mail.

Thank you.

____ ____

Counseling Center Parent Signature

(FEDERAL LAW 99.21 - "No parent signature is required for educational records sent another educational agency.")

SAUGERTIES CENTRAL SCHOOL DISTRICT

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RESIDENCY DOCUMENTATION LIST

All new registrants must have at least two proofs of residence, each a different type.

All documents submitted as proof of residence must:

- be the original document.
- be current (should be issued in last 30 days).
- contain the name of the parent/guardian.
- contain the physical address of the residence.

Examples of proof of residence that will be accepted include:

- ☐ Residential lease, deed, mortgage or other proof of home ownership
- ☐ Notarized/signed statement or affidavit from a third party landlord, owner or tenant with whom you are sharing property
- ☐ Documents issued by federal, state or local agencies (i.e. Social Security statement, SSI award statement, unemployment statement, welfare benefit statement)
- ☐ Membership documents based upon residency (i.e. library card)
- ☐ Notarized/signed statement from a third party establishing your physical presence in the District
- ☐ Pay stub
- ☐ Utility and/or home service bill (water, electric, gas, propane, oil, refuse/garbage, cable, phone)
- ☐ Federal or NYS income tax form
- ☐ Official driver's license, learner's permit or non-driver identification
- ☐ State or other government issued identification
- ☐ Voter registration documents
- ☐ Insurance Policy (Automobile, home owners, rental, health) - identifying your name and address
- ☐ Bank/Credit Card statement on company letterhead
- ☐ Jury duty notice

SAUGERTIES CENTRAL SCHOOL DISTRICT

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STUDENT REGISTRATION FORM

For Office Use Only

School ______________ **Enter Date** _______ **Grade** _____ **Teacher/HR**__________

Student # ______________ **Out of District** _____ **Non Resident** ______

- **PLEASE PRINT LEGIBLY** This information will be used for your child's school and achievement records. Failure to answer all questions and not printing legibly could delay the registration process.

STUDENT NAME: ______________________ ______________________ ____
Last First MI

DATE OF BIRTH: ______________ **GRADE:** ______________ **GENDER:** Male Female

HOUSEHOLD ADDRESS

RESIDENTIAL ADDRESS: ______ ____________________ ____ ______________
House # **Street Name** **Apt. #** **City or Town**

HOUSEHOLD PHONE NUMBER: (____)______________

MAILING ADDRESS (if different): ________________________ **ZIP** __________

PARENT/GUARDIAN(S) RESIDING AT THE ABOVE ADDRESS:

Last ________________, First ______________
Cell Phone: ____________ Work Phone: __________
Relationship to Student ____________________
(mother, father, guardian, step-parent)

Last:________________, First ______________
Cell Phone: ____________ Work Phone: __________
Relationship to Student ____________________
(mother, father, guardian, step-parent)

Student Resides with: (circle one)

Both Parents at Same Address Mother or Mother/Stepfather
Father or Father/Stepmother Guardian or Foster Parent

If divorced, separated, or guardian, proof of custody must be submitted and verified. Proof of custody may be established through evidence of a separation/divorce agreement, court ordered guardianship documents, or notarized custody affidavit from the parent(s) and/or guardian(s). This information must be provided at the time of registration.

SECONDARY HOUSEHOLD

If both parents are not residing together with the child, extra mailing is requested. (address must be complete)

Parent Name: ____________________ Relationship to Student: ____________________

Residential Address: ________________________ City ____________ ST___ Zip__________

Mailing Address: ________________________ City ____________ ST ___ Zip__________

Household Phone: ________________________ Cell Phone: ____________________

Has this student ever been enrolled in the Saugerties Central School District? ___YES ___NO

If yes, what school? ___Jr/Sr High ___ Cahill ___ Mt Marion ___ Riccardi ___ Morse

ALL CHILDREN - PRE-SCHOOL AGE & SCHOOL AGE RESIDING IN HOUSEHOLD:

Name (Last. First, MI)	Date of Birth	Gender	Grade	Present School
		M___ F___		
		M___ F___		
		M___ F___		
		M___ F___		
		M___ F___		

SAUGERTIES CENTRAL SCHOOL DISTRICT

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Student's Special Programs

Has your child been retained (repeated a grade)? If so, what grade? _____

Has your child received: ___ Counseling ___ Remedial Math ___ Remedial Reading

___ Speech ___ Other (Explain) ____________________

Does your child have an: ___ IEP ___504 Plan

Student's Educational Background

Previous School Name	Previous School Address	School Phone Number	Current Grade

Parent Information

	Living	Deceased	Current Occupation	On Current Active Military Duty
Mother				
Father				

It is the policy of the District that proof of residency be provided within three (3) business days in order to complete enrollment for a student to attend the Saugerties Central School District. The student listed above will be enrolled immediately, or as soon as practicable, pending a final determination by the District that the student is a resident of the District and is entitled to attend the schools of the District on a tuition free basis. Please be advised that, <u>in the event that a family violates the residency requirement, the Saugerties Central School District has the right to bill for back tuition for the period of time that the student(s) attended District schools as non-residents.</u>

____
Initials

I certify that I am a resident of the Saugerties Central School District.

______________________________ ______________________

Signature Date

ANY QUESTIONS/CONCERNS REGARDING REGISTRATION REQUIREMENTS MUST BE REVIEWED BY THE BUILDING PRINCIPAL.

SAUGERTIES CENTRAL SCHOOL DISTRICT

Call Box A, Saugerties, New York 12477 Telephone: (845) 247-6500

STUDENT RESIDENCY QUESTIONNAIRE

THIS QUESTIONNAIRE IS INTENDED TO ADDRESS THE McKINNEY-VENTO ACT 42 U.S.C. 11435. THE ANSWERS TO THIS RESIDENCY INFORMATION HELP DETERMINE THE SERVICES THE STUDENT MAY BE ELIGIBLE TO RECEIVE.

Name of School: ____

Name of Student: ____ ____ Sex:___ M ___F

Last First Middle

Birth Date: _____/______/_____ Age: ___________ Student ID #_______________________

1. Is your current address a temporary living arrangement? _______ YES _______ NO
2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ YES _____ NO
3. Name of previous School District where student was enrolled________________________________
4. What is your school district of choice - Saugerties or previous School District _____________________
5. If Saugerties, please sign attached form (STAC-202)

If you answered YES to the above questions, please complete the remainder of this form before signing. If you answered NO, you may stop here and sign now in the box below.

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

- ☐ In a motel
- ☐ In a shelter
- ☐ With more than one family in a house or apartment
- ☐ Moving from place to place
- ☐ In a place not designed for ordinary sleeping accommodations such as a car, park or campsite.

Name of Parent(s)/Legal Guardian(s) ____

Address ____ Zip _______ Phone___________

Is this a temporary address? ________. If yes, whose address is it_________________________________.

Yes or No First and Last Name

What is the relationship to the student? ____.

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.2002(3)(d).

Signature of Parent/Legal Guardian____ Date__________

For school use:

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____________ ____

Date Gina Kiniry, McKinney-Vento Liaison Signature

➪ ***Please send copy to Gina Kiniry at the Junior/Senior High School***

SAUGERTIES CENTRAL SCHOOL DISTRICT

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Parent/Guardian Emergency Information Form

Please print legibly. To ensure accurate information, it is MANDATORY that parents/guardians **SIGN AND DATE** this Student Information Form for **each student** enrolled within the Saugerties Central School District.

Teacher:	*Homeroom:*	*Student ID:* *Family ID:*	*Date Updated* __/__/__
Student Name	*Last Name*	*First Name*	*MI*
Student Residence Address	*Street/Apt. #*	*City*	*State, Zip*
Student Mailing Address	*Post Office Box*	*City*	*State, Zip*
Student Household Telephone		*Current Grade*	
Student Birth Place (city/state) Student Birth Country		*Students Birth Date*	
Parent/Guardian Name		*Is student a US Citizen* *Date Student Entered US*	*Y or N* *Date: __/__/__*
Elementary Only Early Dismissal Contact	*Name and Telephone:*		

If guardianship or residential address has changed, you must contact the building secretary to request the required change of address form or guardianship filing requirements.

Emergency Contact Information: If a Parent/Guardian cannot be reached, the individuals below are authorized to pick up my child and can be reached during school hours at the numbers listed. **Please list 3 individuals other than the parents.**

Emergency Contact 1	*Relationship*	*Household Telephone*	*Alternate Phone*
			Work________ Cell________
Emergency Contact 2	*Relationship*	*Telephone*	*Alternate Phone*
			Work________ Cell________
Emergency Contact 3	*Relationship*	*Telephone*	*Alternate Phone*
			Work________ Cell________

Emergency & Health Information

In case of serious accident or illness at school, your child will be sent to an emergency medical facility. **If your child is currently under treatment for a medical condition and/or will require medication administration during the school day, you must notify the health office via phone or in person.** Special health forms must be completed and signed by your physician before ANY medication can be administered to your child.

Physician's Name:	Phone:

Health Comments: ____________________

Emergency Comments: ____________________

Parent / Guardian Signature ____________________ **Date:** ________

SAUGERTIES CENTRAL SCHOOL DISTRICT

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School Health Services

Dear Parent or Guardian,

As part of your child's requirements for school, a physical examination has been required for students in Prekindergarten or Kindergarten and in Grades 2, 4, 7, and 10. A physical examination is also required for students new to the school district. This must be done within 30 days of entry. A law was enacted that expands health screenings to include the dental health of students in New York State.

After September 1, 2008, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

Thank you for your cooperation in this health endeavor. Our students benefit when we work together to promote the health and achievement of all students.

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

SAUGERTIES CENTRAL SCHOOLS

Jr. Sr. High Fax(854)247-6759 * Mt. Marion Fax (845)246-4103 * Cahill Fax (845)246-4302 * Morse Fax (845)246-4184 * Riccardi Fax (845) 246-2582

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

HEALTH APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

School: ______________ **Gender:** ☐ M ☐ F **Grade:** ______________

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐Negative ☐ Not done Date: ________
PPD: ☐ Positive ☐Negative ☐ Not done Date: ________
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: ________
Dental Referral ☐ Yes ☐ No ☐ Not done Date: ________

Significant Medical/Surgical History: ☐ See attached ______________________

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: ______________________

Allergies: ☐ **LIFE THREATENING** ☐ Food: ________ ☐ Insect: ________ ☐ Other: ________
☐ Seasonal ☐ Medication: ______________________

PHYSICAL EXAM

Height: ________ Weight: ________ Blood Pressure: ________ Date of Exam: ________

Body Mass Index: ____ ____ . ____				Referral
	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: ________

Specify any abnormality (use reverse of form if needed): ______________________

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: ______________________ Dosage/Time: ______________________

Name: ______________________ Dosage/Time: ______________________

If AM dose is missed at home: ______________________

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

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

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** ______________________ ☐ None

☐ **Known or suspected disability:** ______________________ ☐ Please monitor

☐ **Restrictions:** ______________________ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: ________

(Stamp below)

Provider's Signature: ______________________ Phone: ______________

Provider's Name/Address: ______________________ Fax: ______________

This exam complies with NYSED requirements above and is valid for 12 months, with the exception of any illness or injury lasting more than 5 days that will require review by private healthcare provider and the school medical director.

SAUGERTIES CENTRAL SCHOOL DISTRICT

Call Box A, Saugerties, New York 12477 Telephone: (845) 247-6500

Dental Health Certificate- Optional

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, ask your dentist 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: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ 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

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.

SAUGERTIES CENTRAL SCHOOLS

Health Information for Students Entering K-12

____
Date

Student Name: ______________________ Date of Birth: ______________

Place of Birth: ______________________ Home Phone: ______________

Parent/Guardian Name: ______________________ Emergency Phone: ______________

CHILD'S HEALTH HISTORY

Please check YES or NO to indicate if child has had any of the following conditions. If YES, please provide the requested information.

Condition	No	Yes	Date(s)
Chicken Pox	______ No	______ Yes	Date(s): __________
Rubella (German Measles)	______ No	______ Yes	Date(s): __________
Hepatitis	______ No	______ Yes	Date(s): __________
Mononucleosis	______ No	______ Yes	Date(s): __________
Mumps	______ No	______ Yes	Date(s): __________
Pneumonia	______ No	______ Yes	Date(s): __________
Rheumatic Fever	______ No	______ Yes	Date(s): __________
Scarlet Fever/Strep Throat	______ No	______ Yes	Date(s): __________
High Fever:	______ No	______ Yes	Date(s): __________
Convulsions, Seizures, or Spells	______ No	______ Yes	Date(s): __________

When noting medications, please list ALL medications the student takes, at home or in school. Please see the District's Prescriptive Medication Policy to give permission for medications to be administered in school.

	N / Y	Medication	Dose	Times
Asthma	___N ___Y	________	________	________
Allergies to:	___N ___Y	________	________	________
Medication	___N ___Y	________	________	________
Food	___N ___Y	________	________	________
Insects	___N ___Y	________	________	________
Other (Please specify)	___N ___Y			
________________		________	________	________
Diabetes	___N ___Y	________	________	________
Nosebleeds	___N ___Y	________	________	________
Tuberculosis or Contact with TB	___N ___Y	________	________	________
Heart Condition	___N ___Y	________	________	________

	N / Y	Reason	Dose	Times
Other Medications (Please Specify)	___N ___Y			
________________		________	________	________
________________		________	________	________
________________		________	________	________
________________		________	________	________

Student Name

_______________, _______________

SAUGERTIES CENTRAL SCHOOLS

Health Information for Students Entering K-12

Please check YES or NO to indicate if child has had any of the following illnesses. If YES, please provide the requested information.

Visual Problems	______ No	______ Yes	Specialist:
Wears Glasses	______ No	______ Yes	____________________
Hearing Problem	______ No	______ Yes	Specialist:
Hearing Aid	______ No	______ Yes	____________________
Ear/Nose/Throat Condition	______ No	______ Yes	Specialist: ____________________
Is the child toilet trained?	______ No	______ Yes	
Does the child wet the bed?	______ No	______ Yes	
Has the child had any operations?	______ No	______ Yes	Type and dates: ____________________ ____________________
Has the child been hospitalized?	______ No	______ Yes	Reason and dates: ____________________ ____________________

Please answer the following questions. Write "none" if the question does not apply.

Please list physical deformities or disabilities:

____

____

____

____

____

____

____

Other diseases or conditions (Please describe):

____

____

____

____

____

Student Name

_______________ , _______________

SAUGERTIES CENTRAL SCHOOLS

Health Information for Students Entering K-12

Please list any accidents or injuries the child has had:

____

____

____

____

____

____

____

Is there anything else concerning the health, behavior, or development of this child that the school should know in order to make special provisions? Please describe.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____
Parent Signature

____
Date

SAUGERTIES CENTRAL SCHOOL DISTRICT

District Electronic Web Access Agreement for Viewing Student Information
Via Saugerties Central District Schools Infinite Campus Parent Portal

I am requesting to review my child/children's student information on the Saugerties Central District Schools Internet website. I have read Saugerties Central District Schools User expectations and computer requirements for the Infinite Campus Parent/Student Portal and agree to abide by and support the expectations. I understand, in the interest of security, the District reserves the right to change user passwords or deny access at anytime. By signing this agreement I, as parent/guardian, release the Saugerties Central District Schools from any and all liability for damages arising out of unauthorized access to my parent/guardian account. I agree that I will not share my password or allow anyone other than myself to use the account, including my own child or children.

I agree to protect any information printed or transferred to my computer, or destroy the documentation generated from this site.

I understand that three unsuccessful logins will disable my account. If my account becomes locked it is my responsibility to request my parent portal account to be reset by sending an email request to the parent portal email address of scsdportal@saugerties.k12.ny.us to request my parent portal account be reset. In the email note I will provide the "Personal Login ID" given to me at the time the account was created and answer any questions to verify my identity. In the sole discretion of the District, the account may be unlocked, but I understand that it may take up to 3 – 5 school days to have my account unlocked.

I have checked that the computer I will be using to access the Internet site for viewing student information meets or exceeds the minimum requirements as identified on the Saugerties Central District Schools website.

PLEASE PRINT

List the names of all your children currently enrolled in Saugerties Central District Schools and residing at the address listed below. The information given on this form must match the enrollment information you provided during registration.

Parent / Guardian Name Last Name:		First Name:		
Residential Address:				
Email Address:				
Home Telephone Number:				
Child's first and last name must be printed below as it appears on the birth verification.				
Child's First Name	Child's Last Name	Child's Date of Birth	Name of the Saugerties School your child attends	**To be completed by school – Student ID**

Authorization Agreement Verification

The District Data Administrator Office will keep the completed and signed form in the Parent Portal Folder. The school building secretary or other designated school staff member must witness the parent/guardian signing this form. The parent/guardian must provide a photo ID prior to signing.

Parent / Guardian Signature ____________ Date ______ Please Print Parent / Guardian Name ____________

School Witness Signature ____________ Date ______

*If the parent/guardian cannot visit the school, the parent/guardian must provide a notary public with a valid photo ID< witness the parent/guardian signing this form and use his/her public seal with a current date.

(STATE OF NEW YORK)
SS:
(COUNTY OF ULSTER)

On the _______ day of _____________, 20___, before me personally came _______________________ to me known, and known to me to be the individual described in a who executed the foregoing Agreement, and duly acknowledged to me that he/she executed same.

____
Notary Public

Notary Public Seal

OFFICE USE ONLY
Date Activated: ____________________
Activation Key sent to email address provided: ____________________
Activation Key mailed: ______________

Saugerties Central School District

* Call Box A * Saugerties NY 12477 * (845) 247-6500* Fax (845) 246-8364 * www.saugerties.k12.ny.us *

September 2015

Dear Parents and Guardians:

Parents and guardians should be aware of the District's procedures for students who experience a severe allergic reaction while in school. The following is an outline of the Saugerties Central School District's Emergency Procedures for Allergic Reactions.

I. Identified Students:

Follow order of family physician – MD order and parental permission should be in student's chart in the Health Office. Medication will be kept in Health Office or carried by student, if indicated by MD.

II. Unexpected Reactions - no history of allergies but develops symptoms (itching, flushing, urticaria, angioedema):

1. If insect sting, apply ice.
2. Benadryl by mouth (see below).
3. Report to parent and/or physician.
4. Observe progress of symptoms.

III. Unexpected Severe Reactions (no previous history):

Symptoms include– swelling (especially eyes and tongue), difficulty breathing, altered consciousness, light headedness, poor circulation, wheezing, drop in blood pressure, weak, rapid pulse, cold sweaty skin.

Immediate First Aid -

1. Administer Epi-Pen injection
   Under 50 lbs. – 0.15cc (Epi-Pen Jr.)
   Over 50 lbs. – 0>3cc (Epi-Pen)
2. Repeat Epi-Pen dose if symptoms do not lessen or if they worsen.
3. Follow with Benadryl
   Under 50 lbs. – 1 tsp. (12.5 mg)
   Over 50 lbs. – 2 tsp. (25 mg)
4. Notify Administrator and parent
5. Call 911 for transport to hospital.

Because treatment will include Benadryl and Epinephrine, it is your responsibility to notify the school nurse in writing upon receipt of this letter if your child has ever had a reaction to either treatment.

If you have any further questions, please contact the health office in your child's school.

Sincerely,

Ravi Ramaswami, MD
School Physician

New for 2016-17 School Year

Parents:

All kids entering 7th and 12th grade must have the **meningococcal vaccine.**

Without it, they can't start school.

About the Vaccine:

- It's not a new vaccine. It's been recommended for a decade.
- Most parents already choose to vaccinate their children.
- What's new is that the vaccine will be **required** for school entry as of Sept. 1, 2016.

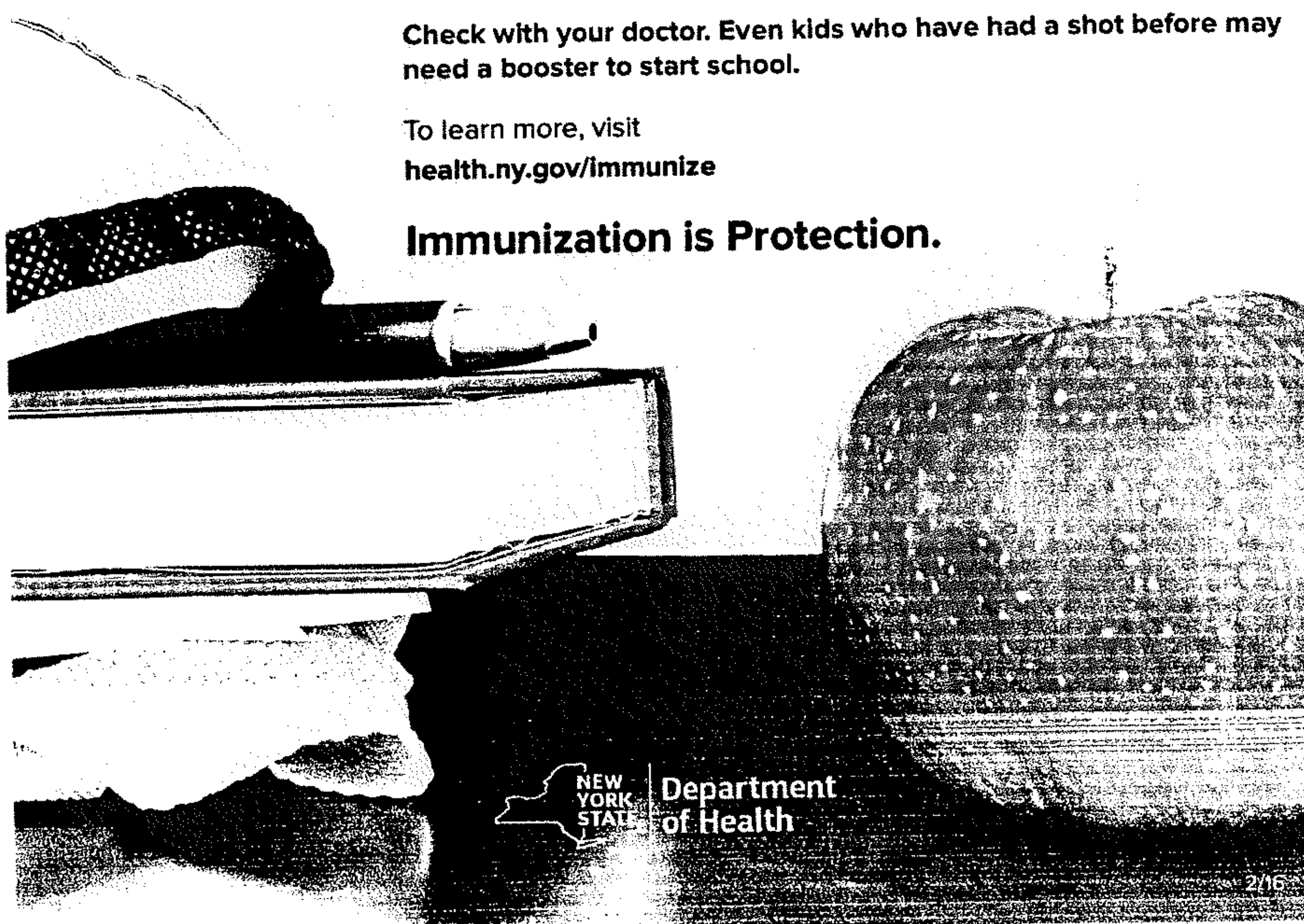
About Meningococcal Disease:

- It causes **bacterial meningitis** and other serious diseases.
- Teens and young adults are at greater risk.
- It comes on quickly and without warning.
- Its symptoms are similar to the flu.
- Every case of this disease can result in death or long-term disability.

Check with your doctor. Even kids who have had a shot before may need a booster to start school.

To learn more, visit
health.ny.gov/immunize

Immunization is Protection.



Saugerties Central School District

Call Box A * Saugerties, NY 12477 * (845) 247-6503 * Fax (845) 246-8364 * www.saugerties.k12.ny.us

Office of the Assistant Superintendent for Curriculum and Instruction

September 2016

Dear Parents and Guardians:

Parents and guardians should be aware of the District's procedures for students who experience a severe allergic reaction while in school. The following is an outline of the Saugerties Central School District's Emergency Procedures for Allergic Reactions.

I. **Identified Students:**
Follow order of family physician – MD order and parental permission should be in student's chart in the Health Office. Medication will be kept in Health Office or carried by student, if indicated by MD.

II. **Unexpected Reactions - no history of allergies but develops symptoms (itching, flushing, urticaria, angioedema):**

1. If insect sting, apply ice.
2. Benadryl by mouth (see below).
3. Report to parent and/or physician.
4. Observe progress of symptoms.

III. **Unexpected Severe Reactions (no previous history):**
Symptoms include– swelling (especially eyes and tongue), difficulty breathing, altered consciousness, light headedness, poor circulation, wheezing, drop in blood pressure, weak, rapid pulse, cold sweaty skin.

Immediate First Aid -

1. Administer Epi-Pen injection
   Under 50 lbs. – 0.15cc (Epi-Pen Jr.)
   Over 50 lbs. – 0>3cc (Epi-Pen)
2. Repeat Epi-Pen dose if symptoms do not lessen or if they worsen.
3. Follow with Benadryl
   Under 50 lbs. – 1 tsp. (12.5 mg)
   Over 50 lbs. – 2 tsp. (25 mg)
4. Notify Administrator and parent
5. Call 911 for transport to hospital.

Because treatment will include Benadryl and Epinephrine, it is your responsibility to notify the school nurse in writing upon receipt of this letter if your child has ever had a reaction to either treatment.

IV. **In the event Narcan needs to be administered - -**

1. It will be given according to the Board of Education policy.
2. 911 will be called for transport to the hospital.
3. Parents and Administrator will be notified.

If you have any further questions, please contact the health office in your child's school.

Sincerely,

Ravi Ramaswami, MD
School Physician