

**Oracle Charter School**

**STUDENT REGISTRATION FORM**

Date of application (today's date): \_\_\_\_\_

Student's CURRENT grade level (in 2009/2010) (circle one): 8<sup>th</sup> 9<sup>th</sup> 10<sup>th</sup> 11<sup>th</sup> 12<sup>th</sup>

**STUDENT INFORMATION:**

Name: \_\_\_\_\_  
*Last* *First* *Middle*

Buffalo ID # 9 0 \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Ethnicity (circle one): Native American African American Hispanic Caucasian Asian Other

Primary language spoken in the home: \_\_\_\_\_

**Parent/Guardian Contact Information:**

\_\_\_\_\_  
*First* *Last* Current Address: \_\_\_\_\_  
*Street*

\_\_\_\_\_  
*City* *State* *Zip*

\_\_\_\_\_  
*First* *Last* Current Address: \_\_\_\_\_  
*Street*

\_\_\_\_\_  
*City* *State* *Zip*

Home phone # \_\_\_\_\_ Is this number listed? (circle one) yes no

Other important contact information: *(Please list guardian work and cell numbers, or other contacts)*

\_\_\_\_\_  
*Number* *type of phone* *Name of Contact* *relationship*

\_\_\_\_\_  
*Number* *type of phone* *Name of Contact* *relationship*

\_\_\_\_\_  
*Number* *type of phone* *Name of Contact* *relationship*

E-Mail: \_\_\_\_\_  
*Name of Contact* *relationship*

E-Mail: \_\_\_\_\_  
*Name of Contact* *relationship*

Where is the student currently living? (select one):

- \_\_\_ In a shelter
- \_\_\_ With another family or other person because of loss of housing or as a result 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

Names of Legally Responsible Adult(s) at this Address: \_\_\_\_\_  
Are there custodial issues about which we should be aware? \_\_\_\_\_

**REQUIRED DATA FOR SCHOOL USE**

Does student qualify for free or reduced price lunch? (circle one)    yes    no

Does student have a current **IEP** (Individualized Educational Plan or Special Education program)?  
(circle one)    yes    no

List all schools previously attended, beginning with the most recent:

<i>School</i>	<i>Grades</i>	<i>Years</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sibling(s):

<i>Name</i>	<i>Grade</i>	<i>Current School</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FOR OFFICE USE ONLY:**

Date Registration Received: \_\_\_\_\_ Entered on Waiting List by: \_\_\_\_\_  
Date Contacted for Open Position: \_\_\_\_\_ Phone # Called: \_\_\_\_\_ Result: \_\_\_\_\_  
Date Contacted for Second Time: \_\_\_\_\_ Phone # Called: \_\_\_\_\_ Result: \_\_\_\_\_

**Acceptance Checklist:**

- Notified parent of registration information     Notified parent of school orientation
- Provided Parent Information Packet     Notified parent of transfer request from previous school
- Arranged Metro Pass     Notified teachers of incoming student
- Removed from Waiting List     Added to Active enrollment     Updated Student Information database

EMERGENCY CONTACT & HEALTH SUMMARY

Student Name: \_\_\_\_\_

STUDENT EMERGENCY INFORMATION

Physician/Clinic: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contacts: (Please list at least one emergency contact other than parents.)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Health Information:

Allergies (food, medication, environmental): \_\_\_\_\_

Current Medication(s): \_\_\_\_\_

During School:      yes      no

Has your child ever had:

Hay fever	Yes	No	Asthma	Yes	No
Anemia	Yes	No	Arthritis	Yes	No
Bladder/Kidney problems	Yes	No	Convulsions/Seizures	Yes	No
Fainting Spells	Yes	No	Diabetes	Yes	No
Ear/hearing problems	Yes	No	Eye/vision problems	Yes	No
Headaches	Yes	No	Contacts/glasses	Yes	No
Frequent Sore throats	Yes	No	Frequent stomach aches	Yes	No
Head injury/concussion	Yes	No	Frequent nose bleeds	Yes	No
Fractures/dislocations	Yes	No	Back/neck problems	Yes	No
Skin rashes	Yes	No	Anxiety/depression	Yes	No
Emotional problems	Yes	No	Menstruation	Yes	No
Chicken pox	Yes	No			

Date began: \_\_\_\_\_

Please explain any items marked Yes: \_\_\_\_\_

Please list any illnesses, hospitalizations, operations, or injuries that have not been listed above:

Please explain any concerns you have about your child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICATION GUIDELINES

New York State Education Law states that for medication to be administered to a student by school personnel, the following guidelines must be adhered to

1. The student's physician must provide a *written statement* indicating the frequency, dosage, route of administration, duration and possible side effects of the medication.
2. The parent must provide a *written statement* requesting that school personnel administer the medication.
3. The parent must give the medication to school personnel. The medication cannot be given to school personnel by the student.
4. The medication must be provided in its original labeled container.

Please note: The above guidelines refer to all prescription medications as well as all over-the-counter medications (Tylenol, etc.)

Below is a form which you may complete if your child needs school personnel to administer medication of any kind during school hours.

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In compliance with New York State Education Law regarding the administration of medication by school personnel, we hereby request the school nurse or other designated person, in the absence of a school nurse, to follow instructions in the treatment of:

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### PHYSICIAN'S INSTRUCTIONS:

Date: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Administration and Frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Other recommendations: \_\_\_\_\_

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Physician Signature: \_\_\_\_\_

Parent Signature: \_\_\_\_\_



Oracle Charter School

**PHOTO RELEASE FOR MINORS**

I, being the Parent/Guardian of \_\_\_\_\_, hereby consent that videotapes, photographs, motion picture film, and/or electronic images for which my child posed, and/or audio recordings made of his/her voice may be used by Oracle Charter School, its assigns or successors, in whatever way they desire, including for television. I give my consent that such photographs, films, recordings, electronic images and the plates, tapes and/or software from which they are made shall be the property of Oracle Charter School, and they shall have the right to sell, duplicate, reproduce, and make other uses of such photographs, films, recordings, electronic images, plates, tapes and software as they may desire free and clear of any claims whatsoever on my part.

IN WITNESS WHEREOF, I have heretofore set my hand, in the State of New York, this

\_\_\_\_\_ day of \_\_\_\_\_, (year) \_\_\_\_\_.

Name of Student \_\_\_\_\_

Name of Parent/Guardian (print) \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number \_\_\_\_\_

## REQUEST FOR RECORDS

To: School Records

Name of Previous School: \_\_\_\_\_

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

The above student wishes to enroll at Oracle Charter School for the \_\_\_\_\_  
School Year. Please include the contents of the student's cumulative records including  
report cards, special education reports (I.E.P.), standardized test scores, science labs and  
discipline records.

Print Name of Parent/Guardian: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Please forward all documents to:

**Oracle Charter School**  
888 Delaware Avenue  
Buffalo, NY 14209  
Telephone: 716-362-3188  
Fax: 716-362-3187

Thank you for your prompt attention to this matter.

## 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, 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: \_\_\_\_\_

Birth Date: // <small>Month Day Year</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
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School: _____	Grade _____
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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.

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: _____	Vision - without glasses/contact lenses	R	L	<i>Referral</i>
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Hearing <input type="checkbox"/> 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: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.*    Rev. 10/3/07