SACKETS HARBOR CENTRAL SCHOOL
ENROLLMENT FORM

Start Date _____ Date Records Requested _____ Date Records Received_____ Immunization Record : Yes/No

Student Name_____
(Last) (First) (M)

Address_____

_____

Previous Address _____

_____

Grade_____ Sex M F Bus#_____ Date of Birth_____

Language Spoken in Home: 1st Language_____ 2nd Language_____

Ethnic Code: (Circle One) American Indian/Alaskan Asian African/American Hispanic White (Non-Hispanic)

Father's Name_____
(Last) (First) (MI)

Mother's Name_____
(Last) (First) (MI)

Father's Telephone #_____
Father's Cell#_____
Father's Email Address_____
Father's Address_____
Father's Occupation_____
Father's Employer_____
Employer's Telephone #_____

Mother's Telephone #_____
Mother's Cell #_____
Mother's Email Address_____
Mother's Address_____
Mother's Occupation_____
Mother's Employer_____
Employer's Telephone #_____

Parent Signature_____ Date_____

FAMILY INFORMATION

List household members:

Last Name	First Name	Relationship to Parent/Guardian	Date of Birth

FIELD TRIP PERMISSION

My child_____ has permission to participate in school sponsored field trips.

Date_____ Signature of Parent/Guardian_____

NO CHILD LEFT BEHIND REQUIREMENT

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

_____ Single Family Home/Apartment
_____ 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)

SCHOOL LAST ATTENDED

School Name_____ District Name_____
School Address_____ Telephone#_____
_____ Fax#_____
Did student have an IEP? Yes_____ No_____ Date_____
Special Services Received: _____

CUSTODIAL INFORMATION

NOTE: The parent with whom the child resided will be considered the custodial parent. However, the non-custodial parent has access to the child's records in the absence of a court order forbidding it. It is the responsibility of the custodial parent to provide the school with any limiting court order. ***A COPY OF ANY COURT ORDER MUST BE SUPPLIED TO THE SCHOOL.***

Does student reside with both birth or adoptive parents? Yes_____ No_____
If **NO**, please fill out the following Child Custody information:

Child Custody Information

Name and address of Custodial Parent with whom the child resides: _____
_____
_____

Name and address of Non-Custodial Parent: _____
_____
_____

If Foster Child or Ward of State, Name of Placement Agency: _____
Address of Agency:_____
_____
Telephone#_____ Placement Date: _____

Do you as a custodial parent, have legal custody through a court order? Yes_____ No_____
If there is a court order, does it limit the non-custodial parent's access to school records? Yes_____ No_____
May the child be release from school to the non-custodial parent? Yes_____ No_____

EMERGENCY AUTHORIZATION

In case of emergency, officials of the Sackets Harbor Central School District are hereby authorized to arrange for medical or dental treatment for the above named student. This authorization includes transportation to an emergency room, first aid, treatment and other action deemed necessary by the official medical staff, or dentist. I understand that the school district cannot assume responsibility for the payment of medical fees or expenses incurred.

Date_____ Signature of Parent or Legal Guardian_____

If my child becomes ill or is injured and I cannot be reached, I authorize the person listed below to act on my place.

Name_____ Address_____

Telephone #_____ Relationship to Student_____

Name_____ Address_____

Telephone #_____ Relationship to Student_____

Name_____ Address_____

Telephone #_____ Relationship to Student_____

Sackets Harbor Central School
215 S. Broad Street
Sackets Harbor, NY 13685

Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES _____ NO _____

In the last three years, **has the parent or guardian of the child enrolling done farm work as a paid job?** (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES _____ NO _____

If yes, what farm did you work on? _____ Where? _____ When? _____




If you can answer **YES** to **BOTH** of the above questions, your family **MAY** qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's Name_____ D.O.B._____ Grade_____

Child's Name_____ D.O.B._____ Grade_____

Child's Name_____ D.O.B._____ Grade_____

Child's Name_____ D.O.B._____ Grade_____

Parents/Guardians

Mother's Name_____ Father's Name_____

Home Address _____ Home Phone # _____

(Street Address)

_____ Work or Message # _____

(city, town or village) (Zip)

School District_____ School Building _____

School Contact Person _____ Contact Number _____

Other Useful information (directions, farm names, best time to contact, etc.) _____

_____

_____

Sackets Harbor Central School
215 S. Broad Street
Sackets Harbor, NY 13685

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí_____NO_____

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Sí_____ NO _____

Si UD dijo que si, ¿en que granja?_____ ¿Donde?_____ ¿Cuándo?_____




Si Usted contestó que Sí a AMBOS preguntas de arriba, su familia PUEDA calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a)_____ Fecha de Nacimiento _____Grado _____

Nombre del niño(a)_____Fecha de Nacimiento_____Grado_____

Nombre del niño(a)_____Fecha de Nacimiento_____Grado_____

Nombre del niño(a)_____Fecha de Nacimiento_____Grado_____

Padres/ Guardianes

Nombre de la Mamá_____ Nombre del Papá _____

Dirección de la Casa _____ Numero de teléfono en casa _____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mensaje _____
(Ciudad o Pueblo) (Código Postal)

Distrito escolar_____ edificio escolar _____

Persona para contactar _____ numero para contactar _____

Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.)

_____

_____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
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 in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 *specify*	❑ Parent 2 *specify*		
	❑ Guardian(s) *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*		❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other *specify*		❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other *specify*		❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School: *Address:*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** *No* *Not sure*
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ **No** ❑ **Yes*** **Please complete 10b below*

10b. ***If referred for an evaluation,* has your child ever *received* any special education services in the past?**
❑ **No** ❑ **Yes – Type of services received:**_____

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ **Parent** ❑ **Other:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

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Cuestionario de Idioma del Hogar (Home Language Questionnaire - HLQ)

Estimados padres o persona en relación parental:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura de él o ella, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:

❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

HOME LANGUAGE CODE

Conocimientos de idiomas
(Por favor, marque todas las opciones que sean aplicables)

1. **¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?** ❑ Inglés ❑ Otro _____ *especifique*
2. **¿Cuál fue el primer idioma que su hijo(a) aprendió?** ❑ Inglés ❑ Otro _____ *especifique*
3. **¿Cuál es el idioma primario de cada padre / tutor?** ❑ Padre 1 _____ *especifique* ❑ Padre 2 _____ *especifique* ❑ Tutor(es) _____ *especifique*
4. **¿Qué idioma o idiomas entiende su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique*
5. **¿Qué idioma o idiomas habla su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique* ❑ No sabe hablar
6. **¿Qué idioma o idiomas lee su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique* ❑ No sabe leer
7. **¿Qué idioma o idiomas escribe su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique* ❑ No sabe escribir

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. **Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela** _____

9. **¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.**

*Sí**	*No*	*No se sabe*
❑	❑	❑

*** En caso afirmativo, por favor explique:** _____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ❑ Poca gravedad ❑ Algo grave ❑ Muy grave

10a. **¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial?** ❑ **No** ❑ **Sí*** **Por favor, llene 10b.*

10b. ***Si se le ha recomendado alguna vez una evaluación,* ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?**

❑ **No** ❑ **Sí – Explique, que forma o formas de educación especial recibió:** _____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

❑ **De nacimiento a 3 años (Intervención Temprana)** ❑ **3 a 5 años (Educación Especial)** ❑ **6 años o mayor (Educación Especial)**

10c. **¿Tiene su hijo(a) un Programa de Educación Individualizada (Individualized Education Program - IEP)?** ❑ **No** ❑ **Sí**

11. **¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?** *(Por ejemplo, talentos especiales, problemas de salud, etc.)*

12. **¿En qué idioma(s) quiere usted recibir la información de la escuela?** _____

_____ Mes: Día: Año: _____

Firma de un padre o de la persona en relación paternal ***Fecha***

Relación con el estudiante: ❑ **Padre** ❑ **Otra:** _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
- ❑ ADMINISTER NYSITELL
- ❑ ENGLISH PROFICIENT
- ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Sackets Harbor Central School
STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Student Name: Last, First, Middle	Date of Birth (Month/Day/Year
	Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ YES, Hispanic

☐ NO, not Hispanic

2. **Select one or more races from the following five racial groups** [For question (2) Check (√) all groups that apply to your child; check (√) at least ONE box.]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.

☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian/Other _____ Date _____

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify):

For district Use Only

Name of School: *Sackets Harbor Central School*

Student Identification Number: _____

Requirements for School Attendance

SACKETS HARBOR CENTRAL SCHOOL

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade.**

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner and **on the approved NYSED Student Health Examination Form** for school.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time.

- A copy of the health examination must be provided to the school within 30 school days from when your child first starts at the school, and when your child starts K , 1st , 3rd, 5th, 7th, 9th, & 11th grades. **If a copy is not given to the school within 30 school days, the school will contact you.**
- A copy of an up to date immunizations record must also be provided to the school within the 14th day of school. Please note the NYS Immunization Requirements for School Entrance/Attendance for the current year. **If a copy is not given to the school within 14 school days, the school will contact you.**
- If your child has an appointment for an exam during this school year that is after the first 30 days of school and/or an appointment for immunizations after the 14th school day, please notify the Health Office with the date.
- For your convenience, a Dental Health Certificate for your health care provider is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Phone: 315-646-3575 Fax: 315-646-1038 Email: jrowell@sacketspatriots.org

Thank you,

Mrs. Rowell BSN, RN 4/2021

SACKETS HARBOR CENTRAL SCHOOL

HEALTH HISTORY

Dear Parent/Guardian:

We would like for your child to gain the most from his/her school experience. In order for us to assist in accomplishing this, it is necessary to have a current Health History.

Name of Student: _____ Date of Birth:_____ M___ F___

Address: _____ Hm Phone: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Father's Name: _____ Mother's Name: _____

Brothers (#) _____ Sisters (#) _____ This child is (#) _____ in the family.

Date entering Sackets Harbor Central School: _____

Physician to be called in case of an emergency: _____ Phone: _____

When did your child last have a physical exam? Date: _____ Doctor: _____

Purpose of exam: _____ Routine check up: _____ Illness/injury (specify): _____

Health Conditions: Please check any that apply and explain below.

___ Asthma ___ Diabetes ___Vision ___Injury ___Allergies

___Hearing ___Heart ___Seizure ___Frequent ear infections

___Headaches ___Head injury ___ADHD ___Tuberculosis

___ COVID -19 ___Long Haulers Syndrome

Does your child take medication? ___No ___Yes - Name of Medication(s) _____

Are there any problems at home which might affect the child's learning? _____

_____

Any restrictions of activities or diet? _____

Is there anything more about your child's health that you think is important for us to know? _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

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

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
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**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **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 Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

Dental Health Certificate- Sackets Harbor Central School

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9, & 11. 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: / / Month Day Year

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).

☐ 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) _____

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

(3/2018)

SACKETS HARBOR CENTRAL SCHOOL

MEDICATION NOTICE

Dear Parent/Guardian:

If you anticipate your son/daughter will need medication (this means prescription and non-prescription medication including inhalers needed for gym, band or sports practices and athletic events) in school, please complete the attached paperwork and give to your child's private physician to complete.

Doctor orders for medications must be renewed each school year. This request is to meet the State Education Department guidelines for the safe administration of medications in school.

All medications, whether they are **prescription or non-prescription / over the counter**, that are to be administered at school must have a doctor's order and the medication must be in its original container.

Please return this completed form including the completed parent permission portion to the School Nurse on the first day of school in September *and/or before the first sport practice.* If you and your physician have completed the second sheet form for the student to self-carry and to self-administer his/her medication, the student may do so. This form must be returned at the time the medication order form is returned. This is especially important for students with an Epi-Pen or an inhaler. **Students are not allowed to transport any medications (prescription or non-prescription / over the counter) to or from school unless they are self-carry / self- administer.**

Please feel free to contact the School Nurse or the building principal if you have further questions: 646-3575.

Sincerely,
Mrs. Jennifer Rowell BSN, RN
School Nurse

SACKETS HARBOR CENTRAL SCHOOL

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

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

I request the school nurse give the medication listed on this plan. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____
Parent/Guardian Signature **Date**

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

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

Diagnosis _____

Medication _____

Dose _____ Route _____ Time(s) _____

Recommendations _____ ICD Code _____

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

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

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

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

_____ _____
Prescriber's Signature **Phone**

_____
Email

Stamp

Return to:

School Nurse: Mrs. Rowell BSN, RN School: Sackets Harbor Central School
School Address: 215 S. Broad Street Sackets Harbor, NY 13685
Phone: 315-646-3575 Fax: 315-646-1038 Email: jrowell@sacketspatriots.org

SACKETS HARBOR CENTRAL SCHOOL

PROVIDER ATTESTATION AND PARENT PERMISSIONS

FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector:_____
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication: _____
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies: _____
- ☐ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

Please return to School Nurse:

School Nurse: Mrs. Rowell BSN, RN		School: Sackets Harbor Central School
Phone #: 3115-646-3575	Fax: 315-646-1038	Email: jrowell@sacketspatriots.org

Emergency Care Plan

FOOD ALLERGY

Student: _____ Grade: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No Allergen(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is give immediately.

STAFF MEMBERS INSTRUCTED:
❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT: Rinse contact area with water if appropriate

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms
Benadryl ordered: ❑ Yes ❑ No Give _____ Benadryl per provider's orders

Epinephrine ordered: ❑ Yes ❑ No **Specific and detailed instructions:** _____
_____
_____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ❑ Medication available on bus ❑ Medication NOT available on bus ❑ Does not ride bus

Special instructions: _____

Primary Care Provider (PCP) print: _____ Phone: _____

Signature of PCP: _____ Date: _____

Parent/Guardian Signature (I agree with above plan provided by the PCP): _____

This plan is in effect for the current school year. Revised 4/2021

Emergency Care Plan

ASTHMA

Student: _____ Grade: _____ DOB: _____

Asthma Triggers: _____ Best Peak Flow: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, Peak Flow of < _____.
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.
- Peak Flow of _____ or below.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

STAFF MEMBERS INSTRUCTED:

❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication as ordered: _____
Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.
Notify school nurse at 315-646-3575 who will call parents/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

- Call 911 (Emergency Medical Services) and inform them that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.
- A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: _____

Primary Care Provider (PCP): _____ Phone: _____

Signature of PCP: _____ Date: _____

Parent/Guardian Signature (I agree with the above plan provided by the PCP): _____

This plan is in effect for the current school year.

Revised 4/2021

Emergency Care Plan

BEE STING/INSECT ALLERGY

Student: _____ Grade: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No Severity of reaction(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly –
It is important that treatment is given immediately.

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

Benadryl ordered: ❑ Yes ❑ No Give _____ Benadryl per provider's orders

Epinephrine ordered: ❑ Yes ❑ No **Specific and detailed instructions:** _____

_____

_____

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ❑ Medication available on bus ❑ Medication NOT available on bus ❑ Does not ride bus

Special instructions: _____

Primary Care Provider (PCP) print: _____ Phone: _____

Signature of PCP: _____ Date: _____

Parent/Guardian Signature: (I agree with above plan provided by the PCP): _____

This plan is in effect for the current school year. Revised 4/2021

SACKETS HARBOR CENTRAL HEALTH OFFICE

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Student Name _____ Birthdate _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

Healthcare provider _____ Phone _____

Address _____ Fax _____

I hereby authorize my child's physician(s) listed above to exchange the following information with the following Sackets Harbor Central School staff:

- ☐ School Nurse
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Audiologist
- ☐ Vision Department
- ☐ Admissions officer
- ☐ School Psychologist
- ☐ School Social Worker
- ☐ _____
- ☐ Immunizations/physical exams to comply with NYS regulations
- ☐ Social History
- ☐ Psychological evaluations/reports
- ☐ Medical clearances as needed following an injury or change in condition
- ☐ Medical orders required for therapy needs; evaluations
- ☐ Authorization for medications during the school day or on school trips
- ☐ Medical condition/ treatment plans that may have an impact in the school environment
- ☐ Physician referral for services (OT, PT)
- ☐ Other _____

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release; however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. This release expires on the last day of the enrollment of the above student in school and may be revoked at any time by sending the request to cancel this permission in writing to the address above. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate provider when requests are made.**

☐ **I waive my right to receive a copy of this notice.**

_____ _____

(Signature of student over 18 or Parent/Guardian)** (Date)

**If a student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, authority to act on student's behalf: _____

This form complies with all HIPAA regulations. **Revised 6/2020**

NYSDOH COVID-19 In-Person Decision Making Flowchart for Student Attendance

Can My Child Go To School Today?

In the past 10 days, has your child been tested for the virus that causes COVID-19, also known as SARS-CoV-2?

YES

Was the test result positive OR are you still waiting for the result?

YES

Your child **cannot** go to school today.

They must stay in isolation (at home and away from others) until 10 days have passed from symptom onset with at least 72 hours after recovery (with resolution of fever without fever-reducing medications) if waiting for the results **OR** if **positive**, the local health department has released your child from isolation.

NO

In the last 10 days, has your child:

- Traveled internationally to a **CDC level 2 or higher COVID-19 related travel health notice country;** or
- Traveled to a noncontiguous state; or
- Been designated a contact of a person who tested positive for COVID-19 by a local health department?

YES

Your child **cannot** go to school today unless:

- For travelers, they have quarantined for 10 days or met the criteria to test out of the 10-day quarantine period.
- For children designated as a contact, until the local health department releases your child from quarantine (at least 10 days).

If your child received a COVID test within 72 hours prior to arriving in NY, they must quarantine for 3 days and can test on the 4th day after arrival. Students who receive a second negative result can return to school.

NO

Does your child currently have (or has had in the last 10 days) one or more of these new or worsening symptoms?

- A temperature greater than or equal to 100.0° F (37.8° C)
- Feel feverish or have chills
- Cough
- Loss of taste or smell
- Fatigue/feeling of tiredness
- Sore throat
- Shortness of breath or trouble breathing
- Nausea, vomiting, diarrhea
- Muscle pain or body aches
- Headaches
- Nasal congestion/ runny nose

YES

Your child **cannot** go to school today.

Your child should be assessed by their pediatric healthcare provider (HCP). Call your child's HCP before going to the office or clinic to tell them about your child's symptoms. If your child does not have a HCP, call your local health department.

NO

Your child CAN go to school today.

Make sure they wear a face covering or face mask, practice social distancing, and remind them to wash their hands!

Report absences, symptoms, and positive COVID-19 test results to your child's school.

SEEK IMMEDIATE MEDICAL CARE IF YOUR CHILD HAS:

- Trouble breathing or is breathing very quickly
- Prolonged fever
- Is too sick to drink fluids
- Severe abdominal pain, diarrhea or vomiting
- Change in skin color - becoming pale, patchy and/or blue
- Racing heart or chest pain
- Decreased urine output
- Lethargy, irritability, or confusion

My child has COVID-19 symptoms. When can they go back to school?

HEALTHCARE PROVIDER (HCP) EVALUATION FOR COVID-19 (can be in-person or by video/telephone as determined by HCP)

HCP Recommends COVID-19 Diagnostic Test OR **HCP Gives Alternate Diagnosis** | **COVID-19 Diagnostic Test Recommended but Not Done and No Alternate Diagnosis** | **Child is Not Evaluated by HCP**

STAY OUT OF SCHOOL
and in isolation until test result is back

Positive Test Result

Your local health department will contact you to follow up.

Your child must remain in isolation (at home and away from others) until your local health department has released them from isolation, which is typically:

- 10 days after symptom onset; **AND**
- Child's symptoms are improving; **AND**
- Child is fever-free for at least 72 hours without use of fever reducing medicines.

While your child is in isolation, **all members of the household must quarantine at home until released by the local health department, OR** until 10 days have passed and you have not exhibited symptoms.

Note: A repeat negative COVID-19 test is not required for return to school.

Negative Test Result

If your child's symptoms are improving **AND** they are fever-free for at least 24 hours without the use of fever reducing medicines, your child **may return to school** with:

- A note from HCP indicating the test was negative **OR**
- Provide a copy of the negative test result.

If your child's HCP provides a diagnosis of a known chronic condition with unchanged symptoms, or a confirmed acute illness (examples: laboratory-confirmed influenza, strep-throat) **AND** COVID-19 is not suspected, then a note signed by their **HCP explaining the alternate diagnosis is required** before your child will be allowed to return to school. They may return to school according to the usual guidelines for that diagnosis.

Note: a signed HCP note documenting unconfirmed acute illnesses, such as viral upper respiratory illness (URI) or viral gastroenteritis, will not suffice.

Your child must remain in isolation at home and is not able to go back to school until your local health department has released them from isolation, which is typically:

- At least 10 days have passed since date of first symptoms; **AND**
- Child's symptoms are improving; **AND**
- Child is fever-free for at least 72 hours without use of fever reducing medicines.

COVID-19 diagnostic testing includes molecular (e.g., PCR) or antigen testing for SARS-CoV-2, the virus that causes COVID-19. Diagnostic testing may be performed with a nasopharyngeal swab, nasal swab, or saliva sample, as ordered by the health care provider and per laboratory specifications. At times, a negative antigen test will need to be followed up with a confirmatory molecular test. Serology (antibody testing) cannot be used to rule in or out acute COVID-19.