



OESJ Central School District  
44 Center Street  
St. Johnsville, NY 13452

Registration Offices:  
Phone: 518-568-2014 (PK - 6)  
518-568-2011 (7 - 12)  
Fax: 518-288-4823 (PK - 6)  
518-282-8917 (7 - 12)

### WELCOME TO OESJ!

Enclosed is all of the information you need to join the OESJ family.

- \_\_\_ A copy of your child's birth certificate
- \_\_\_ Proof of residency (mortgage statement, lease, utility bill, etc.)
- \_\_\_ Current Physical (within one year)
- \_\_\_ Up to date immunization records
- \_\_\_ Custody Paperwork (if applicable)

#### Important Contact Information:

Superintendent of Schools  
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VISIT US AT [WWW.OESJ.ORG](http://WWW.OESJ.ORG)



Central Registration  
 44 Center Street  
 St. Johnsville, NY 13452

Phone: 518-568-2011  
 Fax: 518-568-2797  
 www.oesj.org

Authorization to Release Information

Today's Date: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Parent's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Does your child currently receive Special Education Services    Y    N (please circle)

I authorize the release of the following records:

- \_\_\_ Education records, including but not limited to, achievement (current report card and assessments), attendance, athletic, personal history and disciplinary records.
- \_\_\_ Medical records, including but not limited to, a birth certificate, immunization records Any illnesses, diagnosis, treatment, duration of illness, length of confinement, and Prognosis.
- \_\_\_ Special Education Records (including IEP/504, latest psychological achievement Testing and related services reports) (if applicable)
- \_\_\_ Custody Agreement (if applicable)

By signing below, I release the \_\_\_\_\_ (former school district) from all legal responsibility and liability that may arise from the act I have hereby authorized. I understand the Oppenheim-Ephratah-St. Johnsville Central School District will maintain these records until otherwise indicated by the legal guardian of this child. I also attest that I am this child's legal guardian and I am wholly responsible for this child and their supervision.

Signature of parent or legal guardian \_\_\_\_\_ Relationship \_\_\_\_\_

<p><b>Information to be released from:</b></p> <p>_____          School Name</p> <p>_____          School Address</p> <p>_____          City/State/Zip</p> <p>_____          Phone #                      Fax #</p>	<p><b>Please Mail/Email/Fax Records to:</b></p> <p>Central Registration          Oppenheim-Ephratah-St. Johnsville CSD          44 Center Street          St. Johnsville, NY 13452</p> <p><b>Elementary School (K-6):</b>          Phone: 518-568-2014 ext. 2117          Fax: 518-568-2941 Attn: Carlee Etwood          Email: carlee.etwood@oesj.org</p> <p><b>Jr/Sr High School (7-12):</b>          Phone: 518-568-2011 ext. 3190          Fax: 518-568-2797 Attn: Barbara Baker          Email: barbara.baker@oesj.org</p>
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44 Center Street  
St. Johnsville, NY 13452

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Fax: 518-568-2797  
[www.oesj.org](http://www.oesj.org)

**STUDENT ENROLLMENT FORM**

Student's full legal name: \_\_\_\_\_  
First Middle Last

Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Nickname: \_\_\_\_\_

Is child known by any other name? If so, what is the name? \_\_\_\_\_

Student Age Verification: Birth Certificate \_\_\_\_\_ Baptismal Record \_\_\_\_\_ Passport \_\_\_\_\_ Other\*  
\*if above not available: State or government issued identification, hospital or health records, military dependent identification card.

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ Home  
Language: \_\_\_\_\_

Racial/Ethnic Identification - please answer both of the following questions:

1. Is the student Hispanic, Latino or of Spanish origin? Hispanic, Latino, or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race
- YES NO

2. Select one or more races from the following five racial groups (check all groups that apply to your child).

\_\_\_\_\_ AMERICAN INDIAN or ALASKA NATIVE - a person having origins in any of the Original people of North America.

\_\_\_\_\_ ASIAN - a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent.

\_\_\_\_\_ 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 - 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.

3. Is Parent active or retired military personnel? \_\_\_\_\_

MAIN CONTACT: (Parent(s)/Guardian(s) whom student lives with: \_\_\_\_\_

Parent(s) Name: Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Parent Marital Status: \_\_\_\_\_ Is there a custody issue on this child? \_\_\_\_\_

If yes, who has custody?: \_\_\_\_\_

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

911 Address (actual residence):

\_\_\_\_\_ Street # and name city/village zip code

County of residence: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mom Cell

Phone: \_\_\_\_\_

Dad Cell Phone: \_\_\_\_\_ Parent

E-Mail: \_\_\_\_\_

Student Cell Phone: \_\_\_\_\_ Student

E-Mail: \_\_\_\_\_

**RESIDENCY INFORMATION**

Student resides with: Both Parents: \_\_\_\_\_ Father only: \_\_\_\_\_ Mother only: \_\_\_\_\_

Step-Parent/Guardian: \_\_\_\_\_ Other: \_\_\_\_\_ please specify: \_\_\_\_\_

Is this a foster placement: Yes No If yes, County \_\_\_\_\_ DSS 2999 for required

**PROOF OF RESIDENCY-VERIFICATION PROVIDED:**

\_\_\_\_ Copy of Deed or Mortgage

\_\_\_\_ Paycheck stub

\_\_\_\_ Lease Agreement

\_\_\_\_ Driver's License

\_\_\_\_ Current Utility Bill

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

**EMERGENCY CONTACT #1:**

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

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell

Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Can pick up student from school Yes No

**EMERGENCY CONTACT #2:**

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

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell

Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Can pick up student from school Yes No

**HAS STUDENT EVER ATTENDED OESJ CENTRAL SCHOOL** YES NO

Previous School

Attended: \_\_\_\_\_

School

Address: \_\_\_\_\_

School Phone

Number: \_\_\_\_\_

Did your child receive any of the following services at his/her previous school?

\_\_\_\_ AIS MATH      \_\_\_\_ AIS READING      \_\_\_\_ SPEECH      \_\_\_\_ COUNSELING  
\_\_\_\_ IEP              \_\_\_\_ 504 PLAN              \_\_\_\_ OTHER

**ANY OTHER PERTINENT INFORMATION NECESSARY FOR SCHOOL OFFICIALS**

(Example: Order of Protection, persons NOT to be contacted under any circumstances, persons NOT allowed to pick up student)

\_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent/Guardian or Student*

\_\_\_\_\_  
*Relationship to student*

Date \_\_\_\_\_

**OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CENTRAL SCHOOL DISTRICT  
HOME CONTACT FORM**

Dear Parent/Guardian:

Our school system is concerned not only with educating its pupils, but also with their health and safety. Please complete this form so we have this important information regarding your child and can act appropriately in case of illness, accident or any emergency

**Student's Name:**

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

\_\_\_\_\_ Birthday \_\_\_\_\_ Grade \_\_\_\_\_ Bus \_\_\_\_\_ Pick Up \_\_\_\_\_  
*Last First Middle*

Address \_\_\_\_\_ Phone \_\_\_\_\_ Student Cell: \_\_\_\_\_

Mother's Name/Address \_\_\_\_\_ Phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Mother's Maiden Name/D.O.B. \_\_\_\_\_

Father's Name/Address \_\_\_\_\_ Phone \_\_\_\_\_

E-mail address \_\_\_\_\_ D.O.B. \_\_\_\_\_

Student resides with: (circle) Both Parents Mother Father Legal Guardian

**Student's Siblings:**

Name	Birthdate	Grade	Brother/Sister
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**Parents Place of Employment:**

Father \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

**Student's Physician:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Student's Dentist:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**If my child has to be taken home because of minor illness and I can not be reached, please call:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Special Instruction in case of early dismissal (ex. Take bus to babysitter - please give name/address)  
\_\_\_\_\_

Is there anything concerning the health of this child that the school should know about in order to provide special care?  
\_\_\_\_\_

Is your child taking medication? \_\_\_\_\_ If yes, please list \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_

I grant permission for emergency care to be given if unable to be notified and for the School Nurse to share pertinent information with school staff. \_\_\_\_\_

Parent/Guardian Signature

\*\*\*Are there any changes from the previous school year: Yes [ ] No [ ]\*\*\*



**NOTE TO SCHOOLS/LEAS:** Please assist students and families filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: Oppenheim-Ephratah-St. Johnsville CSD

Name of School: Oppenheim-Ephratah-St. Johnsville CSD

Name of Student: \_\_\_\_\_  
Last First Middle

Gender: Male Female Date of Birth: \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_\_\_  
ID#: \_\_\_\_\_  
Month day year PK - 12 optional

Current Address: \_\_\_\_\_

Previous Address: \_\_\_\_\_ Previous School District: \_\_\_\_\_

Phone: \_\_\_\_\_

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may all be entitled to free transportation and other services.

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

- 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 carp, park, bus, train, or campsite
- Other temporary living situation (Please describe)
- \_\_\_\_\_
- In permanent housing

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

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

Date \_\_\_\_\_

If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment are **not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's education records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

**NOTE TO SCHOOLS/LEAS:** If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed. Rev. 5/21/09

## **INSTRUCTIONS FOR COMPLETING THE ENROLLMENT FORM-RESIDENCY QUESTIONNAIRE**

### **Purpose of the Enrollment Form - Residency Questionnaire**

All LEAs are required to identify students experiencing homelessness. Additionally, all LEAs that receive Title I funds must ask enrolling students about their housing status. SED encourages all LEAs regardless of whether they receive Title I funds to do the same. To collect this information, LEAs may:

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

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

### **Who should fill out the Enrollment Form - Residency Questionnaire?**

A Enrollment Form - Residency Questionnaire should be filled out for all students enrolling in school and for all students who have a change of address in grades preschool - 12. Preschool includes any LEA program for 3-5 year olds, such as pre-k, Head Start, or Even Start. The Form-Questionnaire should be completed by the student's parent, person in parental relation, or in the case of an unaccompanied youth, by the student directly.

### **Confidentiality**

Student housing information should be kept confidential to the maximum extent possible. This information should only be shared with LEA/school staff members who need information about housing status to ensure that the student's educational needs are met. To this end, LEAs may share a student's completed Enrollment Form - Residency Questionnaire with LEA personnel such as:

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

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

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

### **Discussing the Enrollment Form-Residency Questionnaire with Students and Families**

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

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



5. Categorical eligibility for free meals if offered in the LEA, and
6. Access to services provided with McKinney-Vento funds if available in the LEA.

The LEA should also ensure that the parent, person in parental relation, unaccompanied youth is aware that the student's housing status will be kept confidential and will only be shared with those LEA staff responsible for providing services to the student and those responsible for keeping track of how many students are identified as living in temporary housing in the LEA.

LEAs are advised to explain to parents that if a parent claims that his/her child is living in temporary housing, and the LEA wishes to conduct an investigation to verify this information, the LEA may conduct a home visit. However LEAs cannot contact a landlord or building superintendent to verify a student's housing status. Contacting a landlord or building superintendent may be a violation of FERPA, a federal law, and may put the family at risk of losing its housing. If the student is living in a doubled up situation, it may also lead to loss of housing for the primary tenants.

**If the Parent, Person in Parental Relation, or Unaccompanied Youth declines to fill out the Enrollment Form-Residency Questionnaire**

If the parent, person in parental relation, or unaccompanied youth declines to complete the Enrollment Form - Residency Questionnaire, the LEA should note on the form that the parent, person in parental relation, or unaccompanied youth declined to provide the information requested.

**Completing the Form**

If a parent, person in parental relation, or unaccompanied youth enrolling in school indicates that a student is living in one of the five temporary housing arrangements, the school may not require proof to verify where the student is living before enrolling the student. The five temporary housing arrangements are listed below:

1. In a shelter
2. With another family or other person (sometimes referred to as "doubled-up")
3. In a car, park, bus, train, or campsite, or
4. Other temporary living situation

After the student is enrolled and attending classes, the school or LEA is permitted to verify the student's housing arrangements. However, the student must first be enrolled in school. Again, LEAs cannot contact a landlord or building superintendent to verify a student's housing status (see above for more information).

**Definitions of Temporary Housing Arrangements**

*"With another family or other person" (also referred to as "doubled-up")*

LEAs should be aware that students who are sharing the housing of others are eligible for services under the McKinney-Vento Act and State law, if sharing housing is due to loss of housing, economic hardship, or a similar reason.

*"Other temporary living situation"*

In addition to the four examples of temporary housing, students who lack a "fixed, adequate, and regular" nighttime residence are also covered as homeless under the McKinney-Vento Act and State law. This may include unaccompanied youth who have fled their homes or were forced to leave their homes and who do not otherwise meet the definition of "doubled-up."

*"In permanent housing"*

Permanent housing means that the student's living arrangements are "fixed, regular, and adequate."

**Next Steps for LEAs with Students Living in Temporary Housing Arrangements**

If the parent, person in parental relation, or unaccompanied youth indicates that a student is living in temporary housing, the LEA must complete a Designation Form. If the LEA believes additional information is needed before reaching a final decision on the student's eligibility under McKinney-Vento, enrollment should not be delayed and a Designation Form should still be filled out. For more information about determining eligibility see the National Center on Homeless Education's Determining Eligibility Brief, available at: [www.serve.org/nche/downloads/briefs/det\\_elig.pdf](http://www.serve.org/nche/downloads/briefs/det_elig.pdf)

If a student who is identified as homeless was last permanently housed in a different school district, the district of attendance/local district will be eligible for tuition reimbursement from SED for the cost of educating the student. School districts should complete a STAC-202 form if eligible for tuition reimbursement. For more information about STAC-202 forms contact the STAC office at 518-474-7116 or NYS-TEACHS at 800-388-2014.



## HEALTH HISTORY QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Child's place of birth: \_\_\_\_\_  
With whom does the child live? \_\_\_\_\_ Who is legal guardian? \_\_\_\_\_

### Perinatal and Developmental History

1. During pregnancy with this child, did the mother have any of the following:  
\_\_\_ German measles \_\_\_ Bleeding \_\_\_ Medication \_\_\_ Smoke Cigarettes  
\_\_\_ RH Incompatibility \_\_\_ Drink Alcohol \_\_\_ Other \_\_\_\_\_
2. Type of birth: \_\_\_ Normal delivery \_\_\_ forceps delivery \_\_\_ caesarean delivery  
\_\_\_ anesthesia used \_\_\_ other \_\_\_\_\_
3. Was this baby born; \_\_\_ full term \_\_\_ early \_\_\_ overdue, how long? \_\_\_\_\_
4. Birth weight \_\_\_\_\_ Was baby in an incubator? No Yes, how long \_\_\_\_\_
5. At birth did this baby have any: \_\_\_ breathing problems \_\_\_ jaundice \_\_\_ convulsions \_\_\_ other
6. Did the baby go home from the hospital with mother \_\_\_ yes \_\_\_ no
7. Was baby breast or bottle fed? \_\_\_\_\_ How long? \_\_\_\_\_
8. Were there any feeding difficulties? \_\_\_\_\_
9. Did the baby cry excessively? \_\_\_\_\_
10. Did baby babble and coo? \_\_\_\_\_
11. When did child sit up unsupported? \_\_\_\_\_
12. At what age did he/she walk? \_\_\_\_\_
13. Is the child toilet trained? \_\_\_ no \_\_\_ yes, at what age? \_\_\_\_\_
14. At what age did child say first words? \_\_\_\_\_ What were first words? \_\_\_\_\_
15. At what age did child put 2-3 words together? \_\_\_\_\_ Example \_\_\_\_\_
16. How does this child's development compare to other children such as brothers, sisters, playmates? \_\_\_ about the same \_\_\_ faster \_\_\_ slower
17. Has there been anything unusual in your child's development, which you feel is important in order for us to understand your child? \_\_\_\_\_

### Child's Medical Information

1. Does your child have any special health conditions? \_\_\_ no \_\_\_ yes; is so, please describe \_\_\_\_\_
2. Does your child receive any daily medications? \_\_\_ no \_\_\_ yes  
Name of med. \_\_\_\_\_ dose \_\_\_\_\_ purpose \_\_\_\_\_
3. Are there any medications given frequently but not daily? \_\_\_ no \_\_\_ yes  
Name of med. \_\_\_\_\_ dose \_\_\_\_\_ purpose \_\_\_\_\_
4. When did your child last have a physical exam? \_\_\_\_\_  
Doctor's name/address \_\_\_\_\_
5. When did your child last have a dental exam? \_\_\_\_\_  
Doctor's name/address \_\_\_\_\_
6. Are there any restrictions on this child's activity? \_\_\_\_\_
7. Is this child usually \_\_\_ very active \_\_\_ normally active \_\_\_ rather inactive
8. Do you have reason to believe your child has a vision problem? (headaches, blurred vision, eye discomfort) \_\_\_\_\_
9. Does your child wear \_\_\_ glasses \_\_\_ contact lenses?
10. Do you have reason to believe your child has a hearing problem? (doesn't respond spoken words or noises) \_\_\_\_\_
11. Does your child wear hearing aids? \_\_\_ no \_\_\_ yes
12. Does your child have any special dietary needs? \_\_\_ no \_\_\_ yes If yes, what? \_\_\_\_\_

13. Has your child had any of the following:

Date		Physician who treated child (Name and address)
	Measles	
	Rubella (German Measles)	
	Chicken Pox	
	Mumps	
	Scarlet Fever	
	Whooping Cough	
	Polio	
	Meningitis	
	Epilepsy/Convulsions	
	Diabetes	
	Thyroid Problems	
	Undiagnosed illness with high fever	
	Undiagnosed illness with convulsions	
	Speech Distortions	
	Hearing Loss	

14. Does this child have asthma that has been diagnosed by a physician?  yes  no

If yes, what treatment has been prescribed? \_\_\_\_\_

15. Physicians name and address \_\_\_\_\_

**Additional Information**

1. Is this child sick often?  no  yes, please explain \_\_\_\_\_

2. Does any close relative in your family have a history of: (check & indicate relationship to child)

- Diabetes \_\_\_\_\_
- Anemia \_\_\_\_\_
- Learning Problems \_\_\_\_\_
- Cancer \_\_\_\_\_
- Epilepsy \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Sickle Cell Anemia \_\_\_\_\_
- Mental Retardation \_\_\_\_\_
- Birth Defect \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Other \_\_\_\_\_

3. Do you have any other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, please explain: \_\_\_\_\_

**Mental Health**

1. Has your child ever been diagnosed with a mental health condition?

depression  eating disorder  anxiety  OCD  ODD  ADHD

Other \_\_\_\_\_

2. Who was the doctor that made diagnosis? \_\_\_\_\_

Address \_\_\_\_\_

3. Does your child receive any counseling services? \_\_\_ yes \_\_\_ no

4. If yes, what agency provides the counseling? \_\_\_\_\_

5. Does your child take any medications? \_\_\_ yes \_\_\_ no If yes – what medication /dose? \_\_\_\_\_

6. Does your child or any other family member have any emotional or mental health concerns? \_\_\_\_\_

7. Has your child ever had police involvement / been on probation / PINS / Community Service Required? \_\_\_\_\_

8. What is the reason for move from prior school? \_\_\_\_\_

Completed by: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

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





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44 Center Street  
St. Johnsville, NY 13452

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COMMITTEE ON SPECIAL EDUCATION: CSE/CPSE Chairperson: Jessica Derwin  
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518-568-2011 ext. 2103  
FAX: 518-568-7718  
[jessica.derwin@oesj.org](mailto:jessica.derwin@oesj.org)

#### **SPECIAL EDUCATION SERVICES**

If you suspect your child, age 3-21 years of age, has a disability that affects his or her learning, you can make a referral to have your child evaluated to determine if he or she needs special education services. For more details about this process select A Parent's Guide to Special Education at the following New York State Education Department's (NYSED's) website:

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide>

You can also contact our district's chairperson for the Committee on Special Education, as listed above.

**Additional Services Questionnaire**

(if applicable)

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

School they are transferring from: \_\_\_\_\_

**Special Education Services**

Does the student currently have an IEP (Individualized Education Plan)                      Yes                      No

Does your child receive any of the following type of services:

\_\_\_ Consultant Teacher                      \_\_\_ Self-Contained Classroom

\_\_\_ Resource Room                      \_\_\_ Out of District Class (BOCES)

**Related Services**

\_\_\_ Speech and Language Therapy                      \_\_\_ Occupation Therapy

\_\_\_ Physical Therapy                      \_\_\_ Counseling                      \_\_\_ Other, please describe

**Academic Intervention Services**

\_\_\_ Math                      \_\_\_ English Language Arts                      \_\_\_ Science                      \_\_\_ Social Studies

**Other Services**

\_\_\_ 504 Plan                      \_\_\_ English as a second language (ESL) If yes, how many years of Service? \_\_\_\_\_

\_\_\_ Other

OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CENTRAL SCHOOL DISTRICT

New Enterer's Immunization Compliance Form

Every child entering or attending a District school must present proof of immunization in accordance with NYS Public Health Law Section 2164 unless a New York State licensed physician certifies that such immunization may be detrimental to the child's health.

Except for the above exemption, the District may not permit a student lacking evidence of immunization to remain in school for more than fourteen (14) days, or more than thirty (30) days for and out-of-state or out-of-country transferee who can show a good faith effort to get the necessary certification or other evidence of immunization.

The administration will notify the local health authority of the name and address of excluded students and provide the parent/person in parental relation a statement of his/her duty regarding immunization as well as a consent form prescribed by the Commissioner of Health. The school shall cooperate with the local health authorities to provide a time and place for the immunization of these students.

As the parent of a student enrolling in OESJ Schools, I understand that it is incumbent upon me to furnish an up to date immunization record within fourteen (14) days or thirty (30) days (if child is transferring from another state) of my child's admission to school, or my child shall be excluded from school, as mandated by public health law, until required immunizations are received.

---

Student's Name

---

Grade

---

Parent/Guardian Signature

---

School last attended

---

Date



## Dental Health Certificate- Optional

### Oppenheim-Ephratah-St. Johnsville Central School District

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

#### Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date:     /     /         Sex:  Male  Female  
Month Day Year

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.

**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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type:      Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**Risk Factors for Diabetes or Pre-Diabetes:** Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI \_\_\_\_\_ kg/m<sup>2</sup>

**Percentile (Weight Status Category):**  <5<sup>th</sup>     5<sup>th</sup>-49<sup>th</sup>     50<sup>th</sup>-84<sup>th</sup>     85<sup>th</sup>-94<sup>th</sup>     95<sup>th</sup>-98<sup>th</sup>     99<sup>th</sup> and >

**Hyperlipidemia:**  No     Yes     Not Done      **Hypertension:**  No     Yes     Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)</b>
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g}/\text{dL}$				

**System Review and Abnormal Findings Listed Below**

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> 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:	
<b>Vision &amp; Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, &amp; 11</b>					
<b>Vision (w/correction if prescribed)</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
Notes					
<b>Hearing</b> 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.					<b>Not Done</b>
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7		<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> <b>Other Restrictions:</b>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 &amp; 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level.</b> <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, 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.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached			<input type="checkbox"/> Reported in NYSIIS		
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					



Medical Release Form

Mrs. Brown RN School Nurse  
OESJ Elementary School  
6486 STHWY 29, St. Johnsville, NY 13452  
518-568-2014 x2136  
Fax: 518-568-2941

Ms. Karl Scalzo RN School Nurse  
OESJ Jr/Sr High School  
44 Center St, St. Johnsville, NY 13452  
518-568-2011 x3111  
Fax: 518-568-2797

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

This form allows the providers designated below to share medical information concerning your child with the school district. This information will be used to allow health care collaboration to maintain student safety, provide care, or create/modify programming. Please sign and give this form to your healthcare provider and or your school nurse. I, \_\_\_\_\_ authorize my child's healthcare provider(s) listed below to share

(Parent/Guardian Name)

Medical information of my child, \_\_\_\_\_ D.O.B. \_\_\_\_\_ with the District's Physician, School Nurse, Occupational Therapist (OT), Physical Therapist (PT), Speech Therapist (ST), School Counselor, Psychologist, Principal, School Staff working with student or the following individuals:

**List Health Care Providers (Physician, Dentist, Mental Health Care Provider)**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**The healthcare provider may disclose the following protected health information (check all that apply)**

- immunizations       Health Appraisals
- Past Current Medical Condition and Impact on Attendance, Care at School or School Programming
- All of the above       Other \_\_\_\_\_

**The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)**

- To develop care or therapy plans for routine and emergent school management
- To assess the impact of the medical condition(s) on school programming and/or attendance in order to design appropriate education programs.
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and or home tutoring
- Medication delivery or therapy prescriptions
- All of the above
- Other \_\_\_\_\_

**Please select one:**

- This authorization shall expire on my child's last date of enrollment at \_\_\_\_\_
- This authorization is valid for the entire academic school year 20\_\_\_\_/20\_\_\_\_

\*I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

\*I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

\*I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to redisclosure and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of Patient (over 18), parent/guardian

Date \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
Date \_\_\_\_\_  
Witness Signature

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

*New York State Education Department requires an annual physical exam for new entrants students in Grades Pre-K, K 2 4, 7 and 10, sports working permits and triennially for the Committee on Special Education (CSE)*

HOME LANGUAGE QUESTIONNAIRE (HLQ)

<p><i>Dear Parent or Guardian:</i>  <i>In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.</i></p> <p align="center"><i>Thank You</i></p>	<i>TO BE COMPLETED BY SCHOOL PERSONNEL</i>			
	District _____			
	School Name _____		Grade _____	
	Student Name _____			
	Date of Birth _____	Month _____	Day _____	Year _____
	Student Identification Number _____			
	Country of Birth/Ancestry _____			
	Number of years enrolled in school outside U.S. _____			
	Name/Position of school personnel completing this section _____			
	Determination _____ Possible LEP _____ English Proficient _____			

- |   |               |                                     |
|---|---------------|-------------------------------------|
| 1. What language(s) is spoken in the student's home/residence?                        | _____ English | _____ Other _____<br><i>Specify</i> |
| 2. What language(s) are spoken most of the time to the student in the home/residence? | _____ English | _____ Other _____<br><i>Specify</i> |
| 3. What language(s) does the student understand?                                      | _____ English | _____ Other _____<br><i>Specify</i> |
| 4. What language(s) does the student speak?   | _____ English | _____ Other _____<br><i>Specify</i> |
| 5. What language(s) does the student read?  | _____ English | _____ Other _____<br><i>Specify</i> |
| 6. What language(s) does the student Write?   | _____ English | _____ Other _____<br><i>Specify</i> |

7. In your opinion, how well does the student understand, speak, read and write English?
- |                     |                  |                      |                   |
|---------------------|------------------|----------------------|-------------------|
|                     | <i>Very Well</i> | <i>Only a little</i> | <i>Not at all</i> |
| Understands English | _____            | _____                | _____             |
| Speaks English      | _____            | _____                | _____             |
| Reads English       | _____            | _____                | _____             |
| Writes English      | _____            | _____                | _____             |

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

\_\_\_\_\_  
Date

**Acceptable Use Policy  
2024-2025  
Computer and Internet User  
Oppenheim-Ephratah-St. Johnsville School District**

---

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

Grade: \_\_\_\_\_

Homeroom: \_\_\_\_\_

Teacher: \_\_\_\_\_

Student ID: \_\_\_\_\_

Class of: \_\_\_\_\_

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

Student's Signature: \_\_\_\_\_ Parent or Guardian's Signature: \_\_\_\_\_

**PLEASE RETURN TO THE DISTRICT AS SOON AS POSSIBLE. YOUR STUDENT DOES NOT HAVE COMPUTER ACCESS UNTIL THIS IS RETURNED.**

The purpose of the Internet is to provide access to unique resources. Our goal in providing this service to students is to promote educational excellence within the OESJ Schools by facilitating resource sharing and innovation. The use of the computer network is a privilege, not a right! To remain eligible as a user, the use of your account must be in support of and consistent with the educational objectives of the District.

**Acceptable Uses:**

- All use of the Internet must be in support of educationally related inquiry.
- Network user ID's are ONLY to be used by the authorized owner of the account
- All use of messaging software, including e-mail, must be in support of educationally related inquiry.
- Only school-provided devices may be connected to the network.

**Unacceptable Uses:**

- Sharing passwords or seeking passwords belonging to other individuals or making unauthorized entry into another individual's network account.
- Impersonation – real names MUST be used, pseudonyms are not allowed.
- Using profanity, obscenity or language that may be offensive to another user.
- Personal attacks upon others, including attacks that may be interpreted as "bullying" or "cyber-bullying".
- Illegal installation of copyrighted software on District network. Users must respect all copyright issues regarding software, information, all media (i.e., music, video, intellectual property) and attributions of ownership. The unauthorized copying or transfer of copyrighted materials is not acceptable.
- Downloading or uploading pirated or illegal software.
- Publishing, accessing, distributing, downloading, forwarding, or sending any information which violates or infringes upon the rights of others or which would be considered abusive, profane or sexually or ethnically offensive.
- Using the network for financial or commercial gain.
- Downloading computer applications or installing software applications or computer hardware without first having the express permission from the OESJ School District.
- Using the network for illegal activities or political lobbying.
- Accessing or processing pornographic materials, or inappropriate text files.
- Accessing or processing files dangerous to the integrity of the network.
- Creating any inappropriate documents or other digital content.
- Degrading or disrupting equipment, software or system performance.
- Disclosing or disseminating personal information regarding minors (i.e., address, phone number, pictures, social security number and academic standing).
- Bypassing or attempting to bypass any security measures or software the District has in place including but not limited to, internet content filtering, desktop security and anti-virus software.
- **Users shall not use system resources for any non-instructional purpose, including but not limited to: personal email account access (e.g. Hotmail, AOL, Yahoo, Gmail, etc.), personal instant messaging (chatting), social networking sites (e.g. Facebook, MySpace, Twitter), online shopping, online gaming or personal use of streaming media such as online radio stations, music videos or video broadcasts.**

(over, continued)



**EMAIL:**

The OESJ School District reserves the right to monitor users' online activities and to access, review, copy and store or delete any electronic communication or files and disclose them to others as it deems necessary. Users should have no expectation of privacy regarding their use of District property, network and/or Internet access or files, including email. All emails may be subject to the Freedom of Information Law.

**VIOLATIONS:**

This agreement shall serve to protect actions and computer usage that may occur off campus, but have a nexus to the school community that substantially disrupts the work and discipline of the school and places a profound and significant impact on students within the District (i.e. an off-campus student who during non-school hours consistently emails another student's district email with offensive, demeaning and threatening content). This shall not serve to suppress individuality or personal viewpoints, but simply to protect the safety of students and the sound educational environment the District proudly upholds.

Students using the District's computer network and equipment are required to comply with the District's policy and regulations governing the District's computer network both on and off campus. Failure to comply with the policy or regulation may result in disciplinary action as well as suspension and/or revocation of computer access privileges.

Additionally, illegal activities are strongly prohibited. Any information pertaining to or implicating illegal activity will be reported to the proper authorities. Transmission of any material in violation of any federal, state and/or local law or regulation is prohibited.

**DISCLAIMER:**

The OESJ School District makes no guarantee about the quality of the services provided and is not responsible for any claims, losses, damages, costs or other obligations arising from use of the network or accounts. Any additional charges a user accrues due to the use of the District's network are to be borne by the user. The District also denies any responsibility for the accuracy or quality of the information obtained through user access. Any statement, accessible on the computer network or the Internet, is understood to be the author's individual point of view and not that of the OESJ School District, its affiliates, or employees. Accordingly, anonymity is NOT allowed. As an educational institution, we believe that individuals must take responsibility for their actions and words.

The OESJ School District makes no warranties of any kind, either expressed or implied, for the internet access it is providing. The school is not responsible for:

- Any damages users suffer, including, but not limited to, loss of data resulting from delays or interruptions in service;
- The accuracy, nature or quality of information stored on school diskettes, hard drives or servers or gathered through school-provided Internet access;
- Personal property used to access school computers or networks or for school-provided Internet access; or
- Unauthorized financial obligations resulting from school-provided access to the Internet.

**The individual in whose name a system account is issued will be responsible at all times for its proper use. Thus, users have full responsibility for the use of their account. All violations of this policy will be treated as the sole responsibility of the owner of the account. Any violation of this policy must be reported to school administrators.**

I have read the 'District Acceptable Use Policy' and I hereby release the District, its personnel and any institutions with which it is affiliated, from any and all claims and damages of any nature arising from my use of, or inability to use, the District System, including but not limited to claims that may arise from the unauthorized use of the system to purchase products or services. I agree to follow the rules contained in the 'District Acceptable Use Policy' and I understand that if I violate the rules, access to the Internet and/or District can be terminated and I may face other disciplinary measures.

**PHOTO CONSENT FORM**

As a part of the district's promotion of school activities or recognition of student achievement, district staff members or the news media may photograph or video individual students or groups of students, while they are engaged in school activities not normally open to the public. Your child's photographic image may thereafter appear in district publications, school website, newspapers or newscasts.

**PLEASE SEND THE SCHOOL A SEPARATE NOTE IF YOU DO NOT WANT YOUR CHILD'S PICTURE PUBLISHED.**

**Other Important Information**

Parent or Guardian email address: \_\_\_\_\_

Board Approval: 9/18/2013

**OPPENHEIM-EPHRATAH-ST JOHNSVILLE CENTRAL SCHOOL DISTRICT**