



CIRCLE PARK PERMISSION SLIP

During the school year from time to time teachers take their classes to Circle Park, which is across the street from the elementary school. All students need a parent/guardian's permission to go to Circle Park during the school hours. Please check the appropriate box below. If you do check no, your child will come to the main office until his/her class returns from the park.

My son/daughter has my permission to go to Circle park whenever his/her class goes over.

My son/daughter may not go to Circle Park with his/her class. I understand that he/she will sit in the Main Office until the class returns from the park.

Student's Name: _____

Student's Grade: _____

Student's Teacher: _____

Date: _____

Parent/Guardian Signature: _____



ELDRED CENTRAL SCHOOL DISTRICT

ELEMENTARY BABYSITTER FORM

Parental permission form for student to be transported to and/or from an alternate location (other than the student's home address) due to babysitter arrangements:

Student's Name: _____

Age: _____ Grade: _____

Physical Address: _____

Daytime Phone #: _____ Emergency Phone #: _____

Please complete the pertinent information on your babysitter:

Babysitter Name: _____

Babysitter Address: _____

Babysitter Phone#: _____

_____ AM trip to School _____ PM trip Home _____ Both Trips

Days of the Week: _____

Parental Signature: _____ Date: _____

For Transportation Office Use Only:

Date School Notified: _____

Starting Date: _____

Bus Number: _____



PARENT REQUEST FOR UNSUPERVISED STUDENT DROP OFF

I request that my Pre-K through Grade 3 child/children be allowed to get off at the bus stop without a parent, guardian or other adult being there to meet them.

Name: _____ Grade: _____ Bus # _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

If the child is in grade Pre-K through Grade 3 and the responsible sibling is not getting off the bus with them on a specific day, the bus drive WILL NOT let your Pre-K through Grade 3 child off by themselves.

Designated responsible sibling Grade 4-6 that will be getting off the bus:

Name: _____ Grade: _____

Name: _____ Grade: _____

Parental Signature

Date

Printed Name



MACKENZIE ELEMENTARY SCHOOL

1045 Proctor Road, P.O. Box 249, Glen Spey, New York 12737 · Phone 845.456.1100 · Fax 845.856.8579 · www.eldred.k12.ny.us

ELEMENTARY SOCIAL/MEDICAL HISTORY

To be considered by the Committee on Special Education a social/medical history must be obtained as part of New York State Regulations. If you need assistance with this packet, please contact the office of Pupil Personnel at 845-456-1100 x5295 and we will be happy to assist you. **This packet is also required for all new entrants into Mackenzie Elementary School.**

Person(s) providing information: _____

Date: _____

Student Name: _____

Grade: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

Date of Birth: _____ Gender: Male Female

Place of Birth: _____

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

Emergency Contact Person: _____

Contact Address: _____

Contact Home Phone: _____ Alternate Phone: _____

Child Lives With (Check one): Both Biological Parents Father Mother
 Other Explain: _____

If legal custody has been established (copy of court papers must be on file with the office):

Person with legal custody or guardianship: _____

Date Established: _____

ELDRED CENTRAL SCHOOL DISTRICT STUDENT FAMILY HISTORY

1. Pregnancy:

Medications taken: _____

Abnormal factors: _____

Delivery type: _____ Did your child breath right away? Yes No

Did mother smoke cigarettes? Yes No Amount: _____

Did mother take drugs/alcohol? Yes No Amount: _____

2. Illness/Medical problems (include head, fever, poisoning, head colds, ear infections):

3. Infancy:

Sleep habits: _____

Sensitivity to sounds etc.: _____

Birth weight: _____

Age sat up: _____ Age crawled: _____

Age walked: _____ Age weaned: _____

Age talked: _____ Age toilette trained: _____

4. Family information:

List all persons living in the child's household:

Name						
Age						
Grade (if applies)						
Gender						
Relationship						

5. If the child does not live with both biological parents, why?

Parent(s) separated Parent(s) divorced Parent(s) deceased

Visitations: Yes No Frequency: _____

6. If there are other children in the family, do any of them have physical/emotional problems? Yes No Explain: _____

If so, have they received or have you tried to obtain special help for them?

Yes No Explain: _____

7. Are there problems at home that might affect your child's learning? Yes No

Explain: _____

**ELDRED CENTRAL SCHOOL DISTRICT
STUDENT MEDICAL HISTORY**

1. How is healthcare provided for this student?
 Employment Insurance Private Insurance Social Security Insurance Medicaid
 None Other _____
2. When was your child's last physical examination? _____
Name if Physician: _____
3. Does your child have a health problem? (Please check where appropriate)
 Asthma Diabetes Vision Seizures/Convulsions Hearing Anemia
 Heart Hepatitis ADD/ADHD Allergies (list) _____
 Other: _____
4. Has your child had any of the following? Date: _____
 Chicken Pox Mononucleosis Fifth Disease Measles, type: _____
 Mumps Pneumonia Tuberculous Hepatitis
 Scarletina/Scarlet Fever
5. Does any close relative in your family have a history of the following?
 Diabetes Cancer Epilepsy Anemia Hepatitis Birth Defects
 Heart Disease Learning Disorders Respiratory Problems
 High Blood Pressure Sickle Cell Anemia
 Other _____
6. Does your child have any food allergies? Yes No Type: _____
7. Does your child have any dietary food restrictions? Yes No Type: _____
8. Does your child take any medication? Yes No
Explain: _____
9. Does your child have any special health/physical limitations? Yes No
Explain: _____
10. Is there anything about your child's health that you think is important for us to know?

**ELDRED CENTRAL SCHOOL DISTRICT
STUDENT SCHOOL HISTORY**

Previous School (Including Preschool) name: _____

Years Attended: _____

Reason for leaving: _____

Did your child have early intervention services? Yes No

Did your child have an IEP or 504 Accommodation plan? Yes No

Did your child receive any special help or support services? Yes No

Explain: _____

Please list any agencies, therapists, counselors, etc. that may have been involved with your child:

Name of Agency				
Service Provider Name				
Service(s) Provided				
Reason				
Dates				

Has your child ever been involved in a court action? (PINS, Juvenile Detention, etc.)

Yes No Explain: _____

I GIVE PERMISSION FOR THIS INFORMATION TO BE RELEASED TO INDIVIDUALS WHO MAY BE RESPONSIBLE FOR MY CHILD TO ENSURE HIS/HER SAFETY DURING SCHOOL HOURS.

Parents/Guardian Signature

Date

ELDRED CENTRAL SCHOOL DISTRICT
Typical Day Descriptions

1. How is your child's behavior during an average day?

2. How does your child interact with family members?

3. How does your child interact with peers?

4. How does your child interact with adults?

5. What activity do you enjoy doing most with your child?

How often _____ Do problems arise during this time _____

How do you handle them: _____

6. What interests or hobbies does your child have?

**ELDRED CENTRAL SCHOOL DISTRICT
BEHAVIOR CHECKLIST**

Check the behaviors below that apply to your child within the last 6 months

- Makes no sounds Makes sounds but not words
 Says a few words Explain: _____
 Speaks well but was slow in developing speech Repeats words over and over
 Did talk but does not anymore Is clumsy and awkward
 Is often drowsy Has tantrums frequently
 Displays stereotypic behaviors (waves hands in front of face, stares blankly)

Explain: _____

- Engages in destructive behavior, such as:
 Hair pulling Self-biting Self-pinching Head banging
 Other Explain: _____

- Is hyperactive Seldom makes eye contact
 Demands too much attention Is often sluggish or slow moving
 Often has physical complaints (head, stomach) Usually plays alone
 Is disobedient, difficulty with disciplinary control Asks for help when not needed
 Gives up easily Cries, whines or pouts easily

- Does not interact appropriately with:
 Parents Siblings Peers Pets Others Explain: _____

- Physically abuses:
 Parents Siblings Peers Pets Toys, Furniture, etc.
 Other Explain: _____

- Makes unreasonable noise, yells Does not play with toys
 Talks back to parents, other authority figures Rarely obeys requests, commands, etc.
 Overreacts when losing competitions Does not recognize danger
 Has unreasonable fears (darkness, heights, animals, etc.)

Explain: _____

- Runs away frequently Does not observe curfew
 Will not play alone Has sleeping problems
 Has problems at mealtime Selective about foods
 Disruptive at the table Cannot feed self
 Cannot dress self

- Is not toilette trained
- Is toilette trained but:
- Wets bed Wets pants
- Has been known to set fires
- Seems to have a hearing problem
- Has other physical handicap Explain: _____
- Makes negative comments to:
- Parents Siblings Peers Others
- Teases:
- Parents Siblings Peers Others
- Exhibits irritability
- Exhibits sadness
- Had police contact home due to behavior
- Had complaints from neighbors

Lies frequently

- Soils pants
- Steals repeatedly
- Seems to have a vision problem

Other behavioral concerns:

Parent Signature

Date

Signature of Interviewer/Person Reviewing Form

Date