



Enrollment Registration Requirements Checklist

Welcome to the Tiger Family! Please use this checklist to complete the registration process for each of your students.

Completed and signed Registration Form (*please print single sided*):

- | | |
|--|--|
| <input type="checkbox"/> Initial Student Registration Form | <input type="checkbox"/> Transportation Information |
| <input type="checkbox"/> Request for Student Records | <input type="checkbox"/> Student Questionnaire (two pages) |
| <input type="checkbox"/> Housing Questionnaire | <input type="checkbox"/> Chromebook User Guidelines
and Acceptable Use Policy |
| <input type="checkbox"/> Student Support Services | <input type="checkbox"/> Athletic Intent Form (Grades 7-12 Only) |
| <input type="checkbox"/> Student Racial and Ethnic
Identification | <input type="checkbox"/> Interval Health History (three pages) |
| <input type="checkbox"/> Home Language Questionnaire | |

Student's Birth Certificate Baptismal Record Passport

Current Record of Immunizations

Proof of Residency (2 proofs of residency required):

- Lease agreement or notarized statement from landlord that includes the full address of your residence.
- Copy of purchase contract for the residence you will be living in, with letter from attorney that includes date/time of closing.
- Notarized statement from a third party establishing the physical presence of the parent/guardian in their household in the school district.
- Copy of deed.
- Pay stub.
- Income tax form.
- Utility bill.
- Official driver's license, learner's permit, or non-driver ID.
- State or other government issued ID.
- Documents issued by federal, state or other local agencies

Court Custody Papers (if applicable)

- Birth certificate that names the adult registering the child as a biological parent.
- Legal custody papers.
- Notarized signed affidavit (must be authenticated if from outside the United States).

ID# _____



Welcome! Initial Student Registration

Has your child ever been registered in the Hudson Falls School District? Yes No Grade Entering _____

Student's Legal Name: _____
(First) (Middle) (Last)

D.O.B.: _____ Gender: Male Female Non-Binary Primary Phone: _____

Primary Residence: _____

_____, NY _____
City Zip

Court documents or Custodial/Non-Custodial affidavits stating current custody arrangements must be provided to the school district if the student is not living with both parents.

Mother: _____ Home Phone: _____

E-mail: _____ Cell Number: _____

Street Address: _____ Mailing Address: _____
(only complete if different than student)

Add'l Adult in Household: _____ Primary Number: _____

Father: _____ Home Phone: _____

E-mail: _____ Cell Number: _____

Street Address: _____ Mailing Address: _____
(only complete if different than student)

Add'l Adult in Household: _____ Primary Number: _____

Siblings: (living in same household that are expected to attend a school in our district)

Name: _____ D.O.B. ___/___/___ Grade _____ Male Female Non-Binary

Name: _____ D.O.B. ___/___/___ Grade _____ Male Female Non-Binary

Name: _____ D.O.B. ___/___/___ Grade _____ Male Female Non-Binary

Name: _____ D.O.B. ___/___/___ Grade _____ Male Female Non-Binary

Name: _____ D.O.B. ___/___/___ Grade _____ Male Female Non-Binary

Emergency Contact Person(s): When injury, illness, or non-emergency situations occur involving your child, we want to be able to quickly reach families and other responsible adults. In the event that we cannot reach a parent/guardian, please list a person you trust who is available during the day to provide care for your child. (Must be a local contact)

Full Name _____ Relationship: _____ Primary Phone: _____ - _____ - _____

Full Name _____ Relationship: _____ Primary Phone: _____ - _____ - _____

Full Name _____ Relationship: _____ Primary Phone: _____ - _____ - _____

Full Name _____ Relationship: _____ Primary Phone: _____ - _____ - _____



Request For Student Records

Name and address of previous school:

School Phone: _____

Student
Name: _____
Grade: _____ DOB: _____
School Fax#: _____

The above student is transferring to Hudson Falls CSD. Please forward, at your earliest convenience, the following school records to the building indicated below:

- | | |
|--|--|
| <input type="checkbox"/> Academic Record | <input type="checkbox"/> CSE Records |
| <input type="checkbox"/> Health/Immunization Record | (IEP, Social History, Psycho-Educational Evaluation, |
| <input type="checkbox"/> Standardized Test Data | Speech Evaluation, OT/PT Scripts, Medical Records, |
| <input type="checkbox"/> Approx. grades for the current marking period | Medicaid Consent Form) |

Signature of Parent/Guardian: _____ Date: _____
Relationship: _____

I hereby authorize the release of these records to the following school:

- | | |
|---|-------------------------|
| <input type="checkbox"/> Margaret Murphy Kindergarten Center, 2 Clark Street, Hudson Falls, NY 12839
Phone: 518-681-4512 Fax: 518-747-3853 | Grades UPK-Kindergarten |
| <input type="checkbox"/> Hudson Falls Primary School, 47 Vaughn Road, Hudson Falls, NY 12839
Phone: 518-681-4462 Fax: 518-747-3502 | Grades 1-3 |
| <input type="checkbox"/> Hudson Falls Intermediate School, 139 Maple Street, Hudson Falls, NY 12839
Phone: 518-681-4415 Fax: 518-747-2774 | Grades 4-5 |
| <input type="checkbox"/> Hudson Falls Middle School, 131 Notre Dame Street, Hudson Falls, NY 12839
Phone: 518-681-4319 Fax: 518-746-2790 | Grades 6-8 |
| <input type="checkbox"/> Hudson Falls Senior High School, 80 East LaBarge Street, Hudson Falls, NY 12839
Phone: 518-681-4214 Fax: 518-746-9033 | Grades 9-12 |
| <input type="checkbox"/> Hudson Falls Senior High School, 80 East LaBarge Street, Hudson Falls, NY 12839
Phone: 518-681-4114 Fax: 518-681-4149 | Special Education |
| <input type="checkbox"/> Hudson Falls Senior High School, 80 East LaBarge Street, Hudson Falls, NY 12839
Phone: 518-681-4279 Fax: 518-681-4290 | District Registrar |



Housing Questionnaire

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 that 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 also be entitled to free transportation and other services.

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

- | | |
|---|---|
| <input type="checkbox"/> In permanent housing (your own apartment or house) | <input type="checkbox"/> In a shelter |
| <input type="checkbox"/> With another family or other person (sometimes referred to as "doubled") | <input type="checkbox"/> In a car, park, bus, train, or campsite |
| <input type="checkbox"/> In hotel/motel | <input type="checkbox"/> Other temporary living situation (please describe) |

If not in permanent housing, please provide last address:

Parent/Guardian or Eligible Student Signature: _____ Date: _____

Office Use Only: Signature _____ Date: _____



Student Support Services

Does your student receive AIS? (Academic Intervention Services) Yes No If yes, what subjects? _____

Does your student receive special education services? No Yes If yes, please fill out Consent Form

Check all that apply to your child:

- | | |
|--|--|
| <input type="checkbox"/> IEP | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Self-Contained Classroom | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Consultant Teacher | <input type="checkbox"/> 504 Plan |
| <input type="checkbox"/> Resource Room | <input type="checkbox"/> BOCES Placement |
| <input type="checkbox"/> Speech / Language Therapy | <input type="checkbox"/> Other special needs _____ |

Parent/Guardian Signature

Date



Student Racial and Ethnic Identification

Check all groups that apply to your child:

Is the student Hispanic, Latino, or of Spanish origin? Yes, Hispanic No, not Hispanic

Select one or more races from the following:

American Indian or Alaskan Native: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. (For example: Cherokee, Mohawk, Inuit, etc...)

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent. (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: 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

This form will become part of your child's permanent record. The information you provide on this form is confidential and it is protected by the Confidentiality Regulations cited here: "The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number."

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, citizenship, or immigration status.



Home Language Questionnaire

In order to provide your student with the best possible education, we need to determine how well they understand, speak, read and write English.

What language(s) is spoken in the student's home or residence? English Spanish Other _____

What language(s) are spoken most of the time to the student,
in the home or residence? English Spanish Other _____

What language(s) does the student speak? English Spanish Other _____

What language(s) does the student read? English Spanish Other _____

What language(s) does the student write? English Spanish Other _____

In your opinion, how well does the student understand, speak, read, and write English?

Understands English	Very well	Only a little	Not at all
---------------------	-----------	---------------	------------

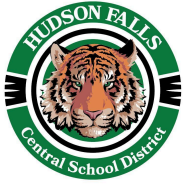
Speaks English	Very well	Only a little	Not at all
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Reads English	Very well	Only a little	Not at all
---------------	-----------	---------------	------------

Writes English	Very well	Only a little	Not at all
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Parent/Guardian Signature

Date



Transportation Information Form

3663 Burgoyne Avenue
Hudson Falls, NY 12839
Office: 518-681-4550
Fax: 518-747-9179

To ensure we have the correct busing information for your child, please fill out and return this form.

Student Name: _____ Grade: _____

*Please check and fill out necessary transportation information:

My child will NOT need transportation

My child will need transportation to and from home address

My child will need transportation to a childcare provider:

If yes, please provide the following information:

AM

PM

Both AM and PM

Daycare/Sitter

Name: _____

Address: _____

Home phone: _____ Cell phone: _____

This form must be mailed or faxed to the above address prior to any changes. Please allow up to one week for changes to occur.

Questions?

Please call our office between the hours of 7:00 am and 3:00 pm Monday through Friday at 518-681-4550

***There is only one pickup and one drop off location per student**



Student Questionnaire

Student Name: _____ Date of Birth: _____

Current Grade: _____ and/or Grade Entering: _____

Are you the legal parent? YES NO (please circle one)

If no, please state relationship to child: _____

ELEMENTARY LEVEL: K- 5

Please Check All That Apply

___ Enjoys school

___ Almost always completes homework

___ Makes friends easily

___ Has difficulty completing homework

___ Is happy and outgoing

___ Has trouble following school rules

___ Follows school rules

___ Is nervous about a new school

___ Gets along well with classmates

___ Has trouble making friends

___ Works independently

___ Is shy and withdrawn

What does your child like the most about school? _____

Is there anything you would like to share that will help us get to know your child?

EDUCATIONAL HISTORY: Please list all prior school districts your child has attended, by grade level.

UPK/Pre-K _____

K _____

1st _____

2nd _____

3rd _____

4th _____

5th _____

6th _____

7th _____

8th _____

9th _____

10th _____

11th _____

Has your child ever been suspended from school? YES NO (please circle)

If yes, what grade level and describe the reason(s) for suspension

Has your child ever received a psychoeducational evaluation?

Yes

No

If yes, at what grade level? _____

Has your child ever been diagnosed with ADD/ADHD?

Yes

No

If yes please note the year/age and physician: _____

Has your child ever exhibited violent or threatening behaviors? Yes No

If yes, please explain:

Is your child/family currently working with any outside service providers such as social service workers, counselors/therapists, drug/alcohol counselors, probation, PINS Diversion, etc.? Yes No

If yes, please list names and agencies of service providers below:

Do we have your permission to share information regarding your child with the above service providers?

Yes No

Do you need information about outside services for your family? Yes No

If yes, please note concerns:

Please note here any specific behavioral/social/emotional concerns that you have about your child:

Please note here any comments/suggestions you may have regarding your child's educational program:

BAND / ORCHESTRA / CHOIR

If your child participates in a music program, please circle which program listed below.

Band 5 6 7 8 9 10 11 12 What Instrument _____ Own Rent

Orchestra 4 5 6 7 8 9 10 11 12 What Instrument _____ Own Rent

Choir 7 8 9 10 11 12

Parent/Guardian Name (please print)

Date _____

Parent/Guardian Signature _____



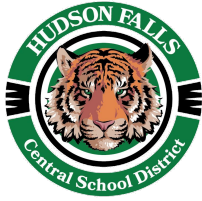
Chromebook User Guidelines and Acceptable Use Policy

HFCSD is pleased to offer our students individual access to Chromebooks in grades K-12. Access to Chromebooks are a privilege, not a right, and are to be used by HFCSD students only. They are provided to enhance, enrich and facilitate teaching and learning. Chromebooks are to be used for school related use, curriculum support, research, communications and other instructional purposes. We believe the advantages to having access to digital resources far outweigh any disadvantages to not providing access to technology in the school environment. To that end, students and staff have participated in appropriate trainings and use Positive Behavior Intervention Strategies to help facilitate the use of technology in the classroom.

The following guidelines are provided to help manage the use of this equipment. These guidelines apply to Chromebooks owned by HFCSD.

- 1.Chromebooks used by school district students remain the legal property of HFCSD.
- 2.Before a Chromebook is issued, the student and parent must sign the HFCSD Chromebook User Agreement, as well as the HFCSD Acceptable Use Policy. Both the User Agreement and the Acceptable Use Policy will remain on file with IT Administration.
- 3.Students will be responsible for any data on the Chromebook outside of the default image. Any intentional malicious activity caused by student data will be the student's sole responsibility.
- 4.In the event of problems with the Chromebook, the user will immediately bring it to the attention of the teacher and/or IT Department.
- 5.Chromebooks will be turned in at the end of the year for all students 6-11 or prior to a student transferring out of the district. Chromebooks can be turned in directly to the IT Dept located in the High School.
- 6.It is the student's responsibility to keep their assigned Chromebook secure and protected at all times.
Safe Care and Use

- 1.Chromebooks should be shut down when not in use to conserve battery life and at the end of each day.
- 2.Never leave Chromebooks in an unsecure location or unattended in a classroom.
- 3.It is your responsibility to return your Chromebook at the end of each day to its designated charging station or arrive at school prepared with a fully charged Chromebook.
- 4.Carry your Chromebook closed. Do not place anything on the keyboard before closing the lid. (pens, earbuds, notebooks)
- 5.Keep drinks, food, lotions, liquids of any kind and other harmful materials away from your Chromebook.



Chromebook User Guidelines and Acceptable Use Policy

- I will take good care of my Chromebook knowing that I will be issued the same Chromebook each year
- I will never leave my Chromebook unattended or in an unsecured or unsupervised location
- I will not loan my Chromebook to others
- I will be responsible for charging my Chromebook
- I will use my Chromebook for educational purposes only
- I will be responsible for all damage caused by neglect or abuse
- I understand any form of cyberbullying or online harassment is strictly prohibited and will result in removal of all email and Internet privileges
- I understand that failure to return my Chromebook if I move or at the end of the school year will be considered unlawful appropriation of public school property
- I understand that the use of the Internet as part of my educational program is a privilege, not a right, and inappropriate use will result in removal of these privileges

This application indicates that you agree and will follow the guidelines and regulations for Internet access and use of your Chromebook.

Student Name: _____

Student Signature: _____

School: _____

Grade: _____

I acknowledge this Chromebook belongs to HFCS D and is intended only for my individual school/district related use. I have read the Chromebook User Guidelines and agree to abide by the terms and conditions of those guidelines.

The terms and conditions of this agreement are subject to change.

I understand that violation of these guidelines may result in disciplinary action by the issuing administrative authority.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

Questions regarding this application may be directed to help@hfcsd.org or by calling 681-4357

Please sign and return to your homeroom teacher or the main office



Athletic Intent to Transfer Form (Grades 7-12 ONLY)

Student Name: _____ Date of HF Registration: _____

Grade Entering: _____ Male / Female / Non Binary: _____ Date of Birth: _____

HF Registered Address: _____

With whom is the student currently living with: _____

Parent/Legal Guardian(s): _____ Primary Telephone: _____

Reason for attending HFCSD: _____

Prior Athletic Information

Previous School: _____

Previous Home Address: _____

With whom did the student live with: _____

Reason for leaving previous school: _____

Sports played in previous school (please indicate level as Modified, JV or Varsity and year played)

Sport: _____ Level(s): _____ Year(s): _____

Sport: _____ Level(s): _____ Years(s): _____

Sport: _____ Levels(s): _____ Years(s): _____

Sport: _____ Levels(s): _____ Years(s): _____

Sport: _____ Levels(s): _____ Years(s): _____

Were you subject to the Athletic Placement Process (APP) as 7th or 8th grader: YES or NO

Academic Information

Year entered 9th Grade (if applicable): _____



TRANSFER NOTIFICATION

This form must be completed for all transfer students and submitted to the Section 2 office. UPON RECEIPT IN THE SECTION OFFICE OF A NOTIFICATION E-MAIL, THE STUDENT IS ELIGIBLE TO PRACTICE; BUT CANNOT PARTICIPATE IN A CONTEST UNTIL APPROVED BY THE SECTION.

Please Note: Make sure all available information/documentation is submitted prior to the Transfer Committee’s review. NO appeal will be entertained involving additional information that WAS AVAILABLE but not included prior to the Transfer Committee’s review.

PLEASE CHECK ONLY ONE (1) of THE FOLLOWING

Waiver Request:

- Financial – Requires documented proof of a significant loss of income or a significant increase in expenses. OR
Health & Safety – Written documentation from the Superintendent of Schools or HS Principal of the previous school indicating the specific circumstances which necessitated the transfer.
School District of Residence (SDR): (No change of residence, school registration change only.) Student is transferring to a school within the district boundaries of his/her residence.

Exemption:

- Divorced/Legally Separated Parents: A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six (6) months. The legal separation agreement or divorce document must address custody, child support, spousal support and distribution of assets and be filed with the County Clerk or issued by a Judge. (proof required)

Parent(s) Signature Attesting to Above

Athletic Director’s Verification

- Homeless: Student declared homeless by the Superintendent under McKinney-Vento Legislation (NYSED 100.2) (STAC on file at the school)

Other Approved Exemption As Listed in the NYSPHSAA Handbook. Please Identify:

No Corresponding Change of Address: This transfer has no corresponding change of address nor does a waiver or exemption apply. We understand that the student is ineligible per the NYSPHSAA Transfer Rule and subject to the limitations contained in NYSPHSAA Handbook #31(b) passed July 2019.

Residency Change: The entire family has abandoned the previous address and physically residing at the current address. I/We attest that our previous residence has been abandoned by the immediate/entire family and our current residence has been established through action and intent. I/We attest that the immediate/entire family will be physically residing at our current address as inhabitants and intend to remain indefinitely. (The mere renting of property within the District does not confer residency. The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA Regulations.) I/We attest that the student has transferred without inducement, recruitment or having sought an athletic advantage. Parent Signature: Date:

By signing this document, I/We attest to the truth and accuracy of any and all information provided on this form.

Parent Signature: Date:

Receiving School: Student’s Name: Date of Birth:
Date of Registration/Transfer: Grade Level: Date Entered 9th Grade Did Student Repeat Any Grades: YES NO
Student/Entire Family Previous Address:
Student/Entire Family Present Address:

Parent(s) Names and Current Addresses

Parent #1: Name Address:

Hudson Falls Central School District NYSED Interval Health History

Student Name:	DOB:
School Name:	Age: Grade:
Physician's Name:	Date of last Health Exam:
List Medications:	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

<i>Does or has your child:</i>			<i>Does or has your child:</i>		
General Health	No	Yes	Breathing	No	Yes
Ever been restricted by a healthcare provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	Ever complained of getting extremely tired or short of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been told by a health care provider they have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>	Devises/Accommodations	No	Yes
Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>	Use a brace, orthotic, or another device?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with hearing or have congenital deafness?	<input type="checkbox"/>	<input type="checkbox"/>	Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with vision or only have vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>	Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Have any ongoing medical conditions? If yes, check all that apply: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	Wear a hearing aid or cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
			Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.	<input type="checkbox"/>	<input type="checkbox"/>
Have Allergies? If yes, check all that apply <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	Digestive (GI) Health	No	Yes
			Have stomach or other GI problems?	<input type="checkbox"/>	<input type="checkbox"/>
			Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>	Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>	Are there any concerns about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>
Brain/Head Injury History	No	Yes	Injury History	No	Yes
Ever had a hit to the head that caused headache, dizziness, nausea, confusion or been told they had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been unable to move their arms or legs or had tingling, numbness or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have a bone, muscle or joint that bothers them?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had migraines?	<input type="checkbox"/>	<input type="checkbox"/>	Have joints that become painful, swollen, warm or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
			Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

Student Name:				DOB:			
Does or has your child				Does or has your child			
Heart Health				Females Only		No	Yes
Ever complained of:		No	Yes	Have regular periods?		<input type="checkbox"/>	<input type="checkbox"/>
Ever had a test by a health care provider for their heart (eg-EKG, echocardiogram, stress test)?		<input type="checkbox"/>	<input type="checkbox"/>	Males Only		No	Yes
Lightheadedness, dizziness, during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	Have only one testicle?		<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, tightness or pressure during or after exercise?		<input type="checkbox"/>	<input type="checkbox"/>	Have groin pain or a bulge or a hernia?		<input type="checkbox"/>	<input type="checkbox"/>
Fluttering in the chest, skipped heartbeats, heart racing?		<input type="checkbox"/>	<input type="checkbox"/>	Skin Health		No	Yes
Ever been told by a health care provider they have or had a heart or blood vessel problem? If yes, check all that apply: <input type="checkbox"/> Chest Tightness or Pain <input type="checkbox"/> Heart Infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> New Fast or Slow Heart Rate <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Has Implanted Cardiac Defibrillator (ICD) <input type="checkbox"/> Has a Pacemaker <input type="checkbox"/> Other:		<input type="checkbox"/>	<input type="checkbox"/>	Currently have any rashes, pressure sores or other skin problems?		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Ever had a herpes or MRSA skin infection?		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	COVID-19 Information		No	Yes
		<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever tested positive for COVID-19?		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	If NO, STOP. Go to Family Heart Health History. If YES, answer questions below:		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Date of positive COVID test:		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Was your child symptomatic?		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Did your child see a health care provider for their COVID-19 symptoms?		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Was your child hospitalized for COVID?		<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?		<input type="checkbox"/>	<input type="checkbox"/>
Family Heart Health History							
A relative has/had any of the following: Check all that apply:							
<input type="checkbox"/> Enlarged Heart/Hypertrophic Cardiomyopathy/Dilated Cardiomyopathy <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy <input type="checkbox"/> Heart rhythm problems, long or short QT interval <input type="checkbox"/> Heart Attack at age 50 or younger				<input type="checkbox"/> Brugada Syndrome <input type="checkbox"/> Catecholaminergic Ventricular Tachycardia <input type="checkbox"/> Marfan Syndrome (aortic rupture) <input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)			
A family history of:							
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50? <input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning or car accident before age 50?				<input type="checkbox"/> Structural heart abnormality, repaired or unrepaired?			
If you answered NO to all questions, STOP , Sign and date below. GO to page 3 if you answered YES to a question.							
Parent/Guardian Signature:				Date:			

Student Name:

DOB:

If you answered YES to any questions, give details, sign and date below.

Parent/Guardian Signature: Date: