

Reminder:

The attached forms must be completed for registration and brought to the main office by Friday April 30th

Please Make Sure to Include:

- . Child's Birth Certificate**
- . Child's Immunization Record**
- . Proof of Residency**



Welcome to our School District

We look forward to having you as part of our school family.

To enroll your child(ren), please complete the attached enrollment packet (one for each child).

Enrollment Packet Checklist

- | | |
|---|--|
| <input type="checkbox"/> Student Enrollment Form | <input type="checkbox"/> Home Language Questionnaire |
| <input type="checkbox"/> Student Age Verification | |
| <input type="checkbox"/> Proof of Residency | |
| <input type="checkbox"/> Prior School Records | |
| <input type="checkbox"/> Health/Medical Packet | |
| <input type="checkbox"/> Immunization Records | |

Return completed enrollment packet to the appropriate school office:

K-5	Mrs. Amy Booth, East Hill Elementary School	518-673-6310	518-673-3887 (fax)
6-8	Mrs. Melissa Skandera, Canajoharie Middle School	518-673-6320	518-673-5557 (fax)
9-12	Mrs. Tracey Stetin, Canajoharie High School	518-673-6336	518-673-8116 (fax)
CPSE	Miss Shayna Skandera, Pre-School Special Education	518-673-6307	518-673-4131 (fax)

Superintendent Mr. Nick Fitzgerald 36 Scholastic Way Tel: 518/673-6302 Fax: 518/673-3177	Director of Finance Leah S. Schaffer 136 Scholastic Way Tel: 518/673-6340 Fax: 518/673-4131	High School Principal Nicholas Bottino 136 Scholastic Way Tel: 518/673-6330 Fax: 518/673-3177	Middle School Principal Christopher R. DePaolo 25 School District Road Tel: 518/673-6320 Fax: 518/673-5557	Elementary Principal Alicia D'Ambrosio 25 School District Road Tel: 518/673-6310 Fax: 518/673-3887	Director of Special Education Jennifer Schwabrow 136 Scholastic Way Tel: 518/673-6307 Fax: 518/673-4131
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Student Cell Phone: _____ Student E-Mail: _____

ORDER OF PROTECTION*: ___ Yes ___ No

*if an order of protection exists, it must be submitted to building principal at time of student enrollment.

Student resides with: Both: ___ Father Only: ___ Mother Only: ___ Step-Parent/Guardian: ___

Other: (please specify) _____

Sibling Information

Name (First and Last)	Gender	Birth Date	Living at Home	Present Grade	School Attending

(List additional siblings on back)

Is this a foster placement: ___ Yes ___ No If yes, name of county
If Yes, copy of DSS 2999 Form required

____ Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement. The answer you give 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 and may be entitled to free transportation and other services.

Do you prefer to remain in your (circle one) SCHOOL OF ORIGIN or ATTEND CANAJOHARIE?

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 car, park, bus, train, or campsite
- Other temporary living situation (please describe) _____

PROOF OF RESIDENCY VERIFICATION PROVIDED:

- Copy of deed or mortgage
- Lease agreement
- Current utility bill
- Paycheck stub
- Driver's license
- Other: _____

EMERGENCY CONTACT #1:

Name _____ Address _____ City _____ State _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to Student: _____ Can pick up student from school (circle one) YES NO

EMERGENCY CONTACT #2:

Name _____ Address _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to Student: _____ Can pick up student from school (circle one) YES NO

HAS STUDENT EVER ATTENDED CANAJOHARIE CENTRAL SCHOOL (circle one) YES NO

Previous School Attended: _____

Address: _____

Telephone: _____ Street _____ City _____ State _____ Zip _____
Fax: _____

Services at previous school: _____ AIS Math _____ AIS Reading _____ IEP _____ 504 Plan _____ Speech
_____ Counseling _____ 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 (for unaccompanied homeless youth) Relationship to student _____

Date: _____

FOR OFFICE USE ONLY

Date Entered: _____ Disability Code: _____

Parental Release Received: _____

Homeroom: _____ Locker #: _____ Combo #: _____

AM Bus #: _____ AM Stop: _____ PM Bus#: _____ PM Stop: _____

AM Drop Off: _____ Walk: _____ PM Pick-Up: _____ Walk: _____

CANAJOHARIE

CENTRAL SCHOOLS
CANAJOHARIE, NEW YORK 13317

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AUTHORIZATION TO RELEASE INFORMATION

Student Name: _____
Date of Birth: _____
Date of Entry: _____

Prior School District: _____
Address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

- _____ Files needed for the above named student for registration at Canajoharie Central School.
- _____ Files are being requested for above named student for enrollment consideration at this time. Student should remain enrolled in current placement. Notification of enrollment will be confirmed.

This is to request and authorize the release of the following records/pertinent information:

- _____ Transcript of Grades
- _____ Withdrawal Grades (at time of transfer)
- _____ RCT/Regents/Proficiency Scores
- _____ Grading Key
- _____ Semester Grades
- _____ Standardized Test Scores and State Assessment
- _____ AIS/Remediation/Support Records
- _____ Health and Immunization Records
- _____ Copy of Birth Certificate
- _____ Individualized Education Plan (IEP)
- _____ Psychological Evaluation
- _____ Social History

Please send records to:

_____ Canajoharie High School
Guidance Office
136 Scholastic Way
Canajoharie, NY 13317
Telephone: 518-673-6336
Fax: 518-673-8116

_____ Canajoharie Middle School
25 School District Road
Canajoharie, NY 13317
Telephone: 518-673-6320
Fax: 518-673-5557

_____ East Hill Elementary School
25 School District Road
Canajoharie, NY 13317
Telephone: 518-673-6310
Fax: 518-673-3887

_____ Canajoharie Central School
Special Education Office
136 Scholastic Way
Canajoharie, NY 13317
Telephone: 518-673-6307
Fax: 518-673-4131

Parent/Guardian Signature _____ Date: _____
(Student 18 years of age)

Superintendent Mr. Nick Fitzgerald 136 Scholastic Way Tel: 518/673-6302 Fax: 518/673-3177	Director of Finance Leah S. Schaffer 136 Scholastic Way Tel: 518/673-6340 Fax: 518/673-4131	High School Principal Nicholas Bottino 136 Scholastic Way Tel: 518/673-6330 Fax: 518/673-3177	Middle School Principal Christopher R. DePaolo 25 School District Road Tel: 518/673-6320 Fax: 518/673-5557	Elementary Principal Alicia D'Ambrosio 25 School District Road Tel: 518/673-6310 Fax: 518/673-3887	Director of Special Education Jennifer Schwabrow 136 Scholastic Way Tel: 518/673-6307 Fax: 518/673-4131
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Canajoharie

CENTRAL SCHOOL



Canajoharie, New York 13317



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Dear Parent/Guardian:

The district's School Health Services program supports your student's academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings as mandated by the State of New York.

During this school year, the following screenings will be required or completed at school:

Vision

- Distance and near acuity for all newly entering students and students in Pre-K or Kindergarten, Grades 1, 3, 5, 7, and 11.
- Color perception screening for all newly entering students.

Hearing

- Hearing screening for all newly entering students and students in Pre-K or Kindergarten, Grades 1, 3, 5, 7, and 11

Scoliosis

- Scoliosis (spinal curvature) screening for all girls in grades 5 and 7, and boys in grade 9.

A letter will be sent home if your student needs follow-up with your health care provider. **For vision screenings only, parents will be notified of all results.** Please call the school's Health Office if you have any questions or concerns.

Sincerely,

Alicia Downs RN BSN
High School Nurse
District Wide RN BSN
Phone: 518-673-6334
FAX: 518-673-6322
136 Scholastic Way
Canajoharie, NY 13317

Haley Baker LPN
East Hill/Middle School
Health Office Nurse
Phone: 518-673-6314
FAX: 518-673-0248
25 District Road
Canajoharie, NY 13317

Health Office Checklist

- **Health Examination** required per child's age, grade and all new entrants. Please see **Health Physical Form which is required**. We also ask that you return the Dental Certificate in this packet.
- **Immunizations** required per child's age or grade. **See New York State Immunization requirements page**.
- **Medication Delivery Information for Parents** page is attached if your child will need to take any medications while at school. This includes any medications – including over the counter medicines (ex. Ibuprofen, Tylenol).
- **Disclosure of Protected Health Information Form**. Although not required, this form allows school medical staff to speak with your child's physician or other medical personnel in regards to your child's school health.

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Dear Parents/Guardians,

New York State law requires a health examination for all students entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade. If a copy is not given to the school within 30 days, the school will contact you.

- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date. An appointment card from your physician is required.
- For your convenience, a physical exam form* for your health care provider is enclosed.
- We realize that it may be difficult to arrange an appointment with your child's doctor. Therefore, a school physical can be provided.

Please check the appropriate line regarding your child's physical and return to the health office:

_____ I've attached a copy of my child's latest physical.

_____ My child has an appointment with our family doctor on _____ and the appointment card is attached.

_____ I request that my child have a school physical.

Student's name _____

Parent/Guardian Signature _____ Date _____

*We suggest that you make copies of the completed forms for your own records before sending them to the school office. Completed forms may also be faxed or mailed.

Sincerely,

Alicia Downs RN BSN
High School Nurse
District Wide RN BSN
Phone: 518-673-6334
FAX: 518-673-6322
136 Scholastic Way
Canajoharie, NY 13317

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25 District Road
Canajoharie, NY 13317

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input checked="" type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

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

BMI _____ kg/m² Percentile (Weight Status Category): <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes Hypertension: No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input checked="" type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated > 10 µg/dL				<input type="checkbox"/> Other: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:				
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <input type="checkbox"/> Brace*/Orthotic <input type="checkbox"/> Colostomy Appliance* <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Insulin Pump/Insulin Sensor* <input type="checkbox"/> Medical/Prosthetic Device* <input type="checkbox"/> Pacemaker/Defibrillator* <input type="checkbox"/> Protective Equipment <input type="checkbox"/> Sport Safety Goggles <input type="checkbox"/> Other:				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached	<input type="checkbox"/> Reported in NYSIIS	Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No		
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

2020-21 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³		Not applicable		1 dose
Polio vaccine (IPV/OPV) ⁴	3 doses		4 doses or 3 doses if the 3rd dose was received at 4 years or older	
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose		2 doses	
Hepatitis B vaccine ⁶	3 doses		3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
Varicella (Chickenpox) vaccine ⁷	1 dose		2 doses	
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable	Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses			Not applicable
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses			Not applicable

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
 - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years, minimum age for grades 8 through 12: 6 weeks)
 - a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

MONTGOMERY COUNTY PUBLIC HEALTH 2021 IMMUNIZATION CLINIC SCHEDULE

20 Park Street, PO Box 1500
County Annex Building
Fonda, NY 12068-1500
518 - 853 - 3531

Location®	Fonda - Tuesday	Fonda - Wednesday
Time®	9:00-12:00	9:00-12:00
Month™		1:00-3:00
	AM	AM/PM
Jan	12th	6th
Feb	2nd	24th
Mar	9th	24th
Apr	6th	21st
May	4th	19th
Jun	8th	23rd
Jul	13th	7th
Aug	24th	4th
Sep	14th	8th
Oct	19th	6th
Nov	23rd	17th
Dec	14th	8th

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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: / / <small>Month Day Year</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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.

OTE: 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.

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): _____

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.



Medication Delivery Information for Parents

Dear Parent or Guardian,

Health care provider and parent permission is needed for all prescription and over-the-counter (OTC) medications used at school or school-sponsored activities.

- **Parent/Guardian(s) must personally deliver all medications to the school health office unless a self-carry order form is signed by a parent and physician.**
- Please bring all medication directly to the school Health Office.
- Please ask the pharmacist to give you a second labeled container for prescription medications so we are able to store the medication properly.

Medication forms are available on our district website or may be obtained from the school Health Office. Your physician may use their own form if desired.

We will be available for medication drop off through school hours.

If you need to make special arrangements to drop off medication, please call to make these arrangements.

Thank you in advance for your cooperation.

Alicia Downs RN BSN

Alicia Downs RN BSN
High School Nurse
District Wide RN BSN
Phone: 518-673-6334
FAX: 518-673-6322
136 Scholastic Way
Canajoharie, NY 13317

Haley Baker LPN

Haley Baker LPN
East Hill/Middle School
Health Office Nurse
Phone: 518-673-6314
FAX: 518-673-0248
25 District Road
Canajoharie, NY 13317

PHYSICIAN AND PARENT'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

**** Must be completed by physician and parent ****

A. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

Physician's Signature _____ Date: _____

Address: _____ Phone: _____

Plan reviewed with parent(s)/guardian(s):

Parent Signature: _____ Date: _____

B. To be completed by the parent or guardian:

I request that my child _____ DOB _____
receive the medication as prescribed above by our physician. The medication is to be
furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date: _____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.

Lanajonarie Central School District

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:

Name _____ Phone _____ FAX _____

Name _____ Phone _____ FAX _____

Name _____ Phone _____ FAX _____

to release the medical records of my child, _____, DOB _____

to the district's: Medical Director School Nurse Athletic Trainer (AT) Counselor Occupational Therapist (OT) Physical Therapist (PT) Psychologist Social Worker Speech Therapist (ST)

other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)

Immunizations Health Appraisals Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy Other _____

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

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational, school, or athletic programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- 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
- At patient's request with no specified purpose
- Other _____

PARENT: Please select one.

This authorization is valid for the entire academic school year 20 - 20

This authorization is valid for the duration of attendance within the school district

This authorization shall expire on ___/___/___ (MO/DD/YR)

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 re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

Signature of Parent/Guardian or student if over 18 _____

Relationship _____

Date _____

Student Name: _____

Grade: _____

Building: _____

Canajoharie Central School District Student Agreement: Acceptable Use of Technology

The Canajoharie Central School District believes that all students and staff should have access to functional computers, software, training, and networking abilities to enable seamless technology integration into the curriculum for an effective and efficient learning environment. The Board of Education will provide access to various computerized information resources through the District's computer system ("DCS") consisting of software, hardware, computer networks, and electronic communications systems. This may include access to email, on-line services, and the Internet. It may include the opportunity for some students to have independent access to the DCS from their home or other remote locations. All use of the DCS, including independent use off school premises, will be subject to this policy. Further, all DCS use must be in support of education or research and consistent with the goals and purposes of the District. All users are reminded that use of the network is a privilege, not a right.

In order to use school technology, students must accept the following responsibilities:

STUDENTS MUST:

Protect individual account and system security.

- Students will take all reasonable precautions to prevent others from gaining access to their individual account. Under no circumstances should a password be shared with others.
- Students will immediately notify faculty of possible or existing security problem. Students will not attempt to remedy the problem on their own.

Respect and protect the intellectual property of others:

- Students will not infringe on copyrights (downloading of pictures, games, photographs, movies, etc...)
- Students will not plagiarize.

Handle all equipment with care and respect:

- Students will handle all school technology equipment with reasonable care and respect.
- Students are responsible for reporting broken equipment to faculty or administration immediately.
- Students will not attempt to repair equipment on their own.

Respect the privacy of others:

- Students will not repost or resend messages sent to them by another person without the express permission of that person.
- Students will not post private information about themselves or another person.

Engage in appropriate use personal technology:

- Student use of personal technology during instruction times must adhere to expectations outlined in CCSD Code of Conduct.
- The District shall not be liable for loss, damage, misuses or theft of any personal technology brought to school.

Practice and respect digital citizenship:

- Students will not attempt to gain unauthorized access to this or any other computer system or go beyond your authorized access.
- Students will not attempt to evade district computer filtering software
- Students will not disrupt the computer system or destroy data by spreading computer viruses or by other means.
- Students will not use technology in ways that violates the CCSD Code of Conduct. This includes, but is not limited to engaging in acts of: cyberbullying, harassment, discrimination, defamation, gambling, accessing obscene/vulgar material and conduct any illegal activity. (CCSD Code of Conduct)
- Students will avoid use of all non-approved commercial social media/networking on school devices.
- Students will use the system only for educational and career development activities.
- Students will not install, upload or download programs
- Students will not engage in spamming.

Consequences of Violation:

Failure to comply may result in suspension of access to the district's computer systems and/or other appropriate penalties.

Parent/Guardian Acknowledgement: I acknowledge and understand the obligations of my student:

Parent Name: _____

Parent Signature: _____

Date: _____

Canajoharie Central School District 1 to 1 Chromebook Agreement

Dear Parents and Students;

The Canajoharie Central School District is implementing a program that will distribute Chromebooks to all students in grades six through twelve. The implementation of these devices are strictly as an educational tool. Students will have use of their assigned Chromebooks throughout their education in our school district. Devices will be turned in at the end of each school year for cleaning and maintenance, and will be re-distributed to students the following fall.

Technology plays a vital role in the educational process in the Canajoharie Central School District. In order to ensure proper care and usage of a school issued Chromebook, students must abide by the *Canajoharie CSD 1 to 1 Chromebook Agreement*. Students will be held accountable for any violation of this agreement. It is mandatory that all students and parents sign this agreement and have an understanding of this policy.

Computer Conduct

The Canajoharie Central School District's technology equipment shall be used for educational purposes consistent with the district's mission and goals. We do expect the use of our Chromebooks to follow both the Canajoharie Central School District Code of Conduct and Acceptable Use Policies

Prohibited Uses

Prohibited uses of the District owned Chromebooks include, but are not limited to:

1. Downloading or playing games and music.
2. Peer to Peer (music file sharing) software.
3. Students are never to access someone else's account or allow anyone to use their account.
4. The Internet is to be used for research and as a means of obtaining needed instructional information.
5. Attempting to access pornographic materials, vulgarity, gambling, militant/extremist material, etc.
6. YouTube is accessible for educational purposes: it should not be used for entertainment purposes.
7. Social networking applications and sites such as Twitter, Facebook, Pinterest, Craigslist, etc.
8. Sound must be turned off except when it is being used for instructional purposes.
9. Students may not deface Chromebooks in any manner. The Chromebook cover should not be decorated. Ex: stickers, decals, markings or drawings with markers, etc.

Proper Care

Proper care of school issued Chromebooks are necessary to allow for the maximum life of the Chromebook. The procedures listed below should be followed:

1. Treat your Chromebook and case with proper respect and care. You will have the same Chromebook and case from grade to grade.
2. The AC adapter should be taken home, plugged in and used to charge your Chromebook nightly. The adapter will remain at home throughout the year.
3. Chromebooks are not permitted in the cafeteria during lunchtime. Your Chromebook is to be stored in your locker during your lunch period.
4. Chromebooks are never to be left unattended. If a Chromebook is found unattended, it will be brought to the library. Acceptable locations to leave Chromebooks include the following: your locker, the library charging location, and a teacher's classroom. Depending on the severity, there may be disciplinary consequences for leaving a Chromebook unattended.
5. Students who take their Chromebooks home are fully responsible for theft and/or damage to the Chromebook.
6. Students are not allowed to have Chromebooks in an unlocked locker room during sporting events.
7. Chromebooks must be transported throughout the building in a safe and protective manner. Students must use the school issued Chromebook case for storing and transporting the Chromebook. Any damage to a Chromebook during the school day should be reported immediately. Otherwise, such damage will be considered negligent.
8. Chromebooks must be charged at home on a daily basis and must be brought to school with a full charge.

In the event that a Chromebook, case and/or charger are damaged, lost or stolen, restitution of \$50 per Chromebook, \$25 per case and \$25 per charger will be assessed at the discretion of district administration.

Parent/Guardian: retain preceding pages for your information

(Turn the following page into your 1st period teacher)

Chromebook User Agreement

The Canajoharie Central School District will provide Chromebooks to all students in the middle school and high school (6-12). Students will keep the Chromebooks with them at school and are encouraged to take them home, upon parent permission.

Students will be responsible for a Chromebook, a case and an AC charger. The charger will be brought home and plugged in an outlet that is safe from potential damage from pets, small children, etc. Students are expected to charge their Chromebooks each night.

Parents/students agree to return the Chromebooks and accessories to the teacher at the end of the designated time frame in the same condition it was issued to the student, less reasonable wear. In the event of loss/damage of any component of the Chromebook, and accessories (ie. case and charging adaptor) the administrative team will meet with the student and parent/guardian to discuss the circumstances which may result in restitution to the Canajoharie Central School District. Please become familiar with the **Chromebook Agreement** and the **Code of Conduct for Technology Acceptable Use and Network Services**, included in this packet.

Furthermore, I accept responsibility for supervision when my child's use of the Chromebook is in a home setting.

STUDENTS AND PARENTS CAN BE CHARGED A \$50.00 FEE FOR THE CHROMEBOOK & CHARGER OR A \$25 FOR THE CASE IF PHYSICAL DAMAGE IS CAUSED BY NEGLIGENT CARE BY THE STUDENT OR IF LOST OR STOLEN.

I have read and understood the above **Chromebook Policy** and **Acceptable Use Policy** and I understand that this Chromebook is an educational tool to be used to enhance the learning process in all subject areas. My signature below signifies that I will abide by the established protocols and have kept the original **Acceptable Use Policy** and **1 to 1 Chromebook Policy** for my reference.

***This agreement must be signed before using school issued technology**

Student Name (Print)

Parent Name (Print)

Student Signature

Parent Signature

Date: _____

Phone Number: _____



Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

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.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL			
DISTRICT		<i>Please print or type clearly</i>	
SCHOOL	GRADE		
STUDENT NAME			
DATE OF BIRTH			
	Month:	Day:	Year:
STUDENT IDENTIFICATION NUMBER			
COUNTRY OF BIRTH / ANCESTRY			
NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.			
NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION			
DETERMINATION:		<input type="checkbox"/> Possible LEP <input type="checkbox"/> English Proficient	

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ *specify*
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ *specify*
- What language(s) does the student understand? English Other _____ *specify*
- What language(s) does the student speak? English Other _____ *specify*
- What language(s) does the student read? English Other _____ Does Not Read *specify*
- What language(s) does the student write? English Other _____ Does Not Write *specify*

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

	Very well	Only a little	Not at all
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other _____

Date _____ Month: _____ Day: _____ Year: _____



Important Bus Information 2021 – 2022

Child's Name: _____

AM: Drop Off _____ Walk _____
Bus From: _____
(address)

PM: Pick Up _____ Walk _____
Bus To: _____
(address)

Canajoharie Central School 2021 - 2022 Calendar

Instructional Days

August 2021

M	T	W	T	F
30	31			

September 2021

M	T	W	T	F
		1	(2)	3
6	(7)	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	

October 2021

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

November 2021

M	T	W	T	F
1	(2)	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

December 2021

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

January 2022

M	T	W	T	F
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

September	-	17
October	-	20
November	-	17
December	-	17
January	-	20
February	-	15
March	-	22
April	-	15
May	-	21
June	-	17
		181
Conference Days	+4	
Total		185

Conference and Recess Days

Sept. 2	Supt. Conference Day
Sept. 6	Labor Day
Sept. 7	Supt. Conference Day
Sept. 8	First Day of Classes
Oct. 11	Columbus Day
Nov. 2	Supt. Conference Day
Nov. 11	Veterans' Day
Nov. 23	Emergency Early Release
Nov. 24-26	Thanksgiving Recess
Dec. 24-31	Holiday Recess
Jan. 17	Martin Luther King Day
Jan. 25-28	Regents Exams
Feb. 21-25	Winter Recess
March 21	Supt. Conference Day
April 15	Good Friday
April 15-22	Spring Recess
May 30	Memorial Day Observed
June 6	3-8 Assessment
June 15-24	Regents Exams
June 20	Juneteenth Observed
June 24	Last School Day

○	Supt. Conference Day
■	School Closed
—	Regents Days
■	NYS Assessment Days

Snow days – School may be closed for emergencies up to four (4) days without adding to the calendar. If there are less than four (4) closings, vacation days will be added in this order accordingly: May 27th, May 31st. If we use more than the allotted number of snow days we will make them up during spring break beginning April 22.

February 2022

M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28				

March 2022

M	T	W	T	F
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
(21)	22	23	24	25
28	29	30	31	

April 2022

M	T	W	T	F
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

May 2022

M	T	W	T	F
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

June 2022

M	T	W	T	F
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	

Adopted: February 11, 2021

Canañoharie Central School



Telephone Directory

OFFICES

High School 673-6330
Middle School 673-6320
Elementary 673-6310

SCHOOL NURSE

High School 673-6334
Middle School 673-6324
Elementary 673-6314

GUIDANCE

High School 673-6336
Middle School 673-6326

SUPERINTENDENT'S OFFICE

673-6302

BUILDINGS & GROUNDS

673-6347

BUS GARAGE

673-6348

BUSINESS OFFICE

673-6340

FOOD SERVICE

673-6346

SPECIAL EDUCATION

673-6307

TAX COLLECTOR

673-5045