HOOSICK FALLS CENTRAL SCHOOL DISTRICT – CENTRAL REGISTRAR

Student Name: _____ Date: _____ Grade: _____

REGISTRATION CHECKLIST

Has your child ever been a student at Hoosick Falls Central School before: ☐ Yes ☐ No

Please complete and bring the following forms to your registration appointment:

- ☐ Student Emergency Information/Registration Form
- ☐ Residency Questionnaire
- ☐ Transportation Information
- ☐ Home Language Questionnaire
- ☐ Record Release Authorization
- ☐ Health History
- ☐ Dental Health Certificate
- ☐ Health Certificate/Appraisal Form
- ☐ Parent and Prescriber's Authorization for Administration of Medication

Proof of Age:

Please bring one of the following documents. If neither is available, please see Appendix A.

☐ Certified Copy of Birth Certificate ☐ Certified copy of record of baptism (if date of birth is shown)

Are you a Hoosick Falls Central School District Resident: ☐ Yes ☐ No

If you checked yes, proceed to number 1. If you checked no, skip number 1 and proceed to number 2.

1. Proof of Residency:

   Please bring THREE of the following documents for proof residency (PO Box not acceptable). See Appendix A for other acceptable forms of proof.

   - ☐ Driver's License (pre-printed on front)
   - ☐ State or other Government Issued ID
   - ☐ Lease Agreement, Deed or Mortgage Statement
   - ☐ Voter Registration Card
   - ☐ If homeowner, current tax bill and/or water bill
   - ☐ Utility bill (dated within 30 days)
   - ☐ Paycheck with current name and address
   - ☐ Social Security or Disability payment
   - ☐ Renter/Homeowner Insurance Bill/Binder (dated within 30 days)
   - ☐ Original Signed Contract to build or buy within 90 days
   - ☐ Bank and/or Credit Union statement (dated within 30 days)

2. Enroll as a tuition-paying student contingent upon available student programming: ☐ Yes

Please also supply the following information/documentation, where applicable:

Custody/Guardianship/Foster Child information:

Do you have Court documents pertaining to the custody of your child? ☐ Yes ☐ No

Do you have guardianship paperwork/foster child paperwork (DSS-2999 Form)? ☐ Yes ☐ No

School Records/Information:

- ☐ Report Card(s)
- ☐ Transcript
- ☐ Labs and/or grades for HS science courses
- ☐ Current Schedule
- ☐ Grades to date (if transferring during a marking period)

Special Education Services:

- ☐ Copy of most recent IEP
- ☐ Copy of most recent 504 Plan

Health Records:

- ☐ Immunization Records (attach to Health Certificate/Appraisal Form)

Other information:

- ☐ Application for Free and Reduced Lunch
- ☐ Pesticide Use/48-hour notification opt-in form

Superintendent: _____ Central Registrar: _____

For Office Use Only

☐ **New Student** ☐ **Re-Entry** Effective Date: _____

☐ **ID# Assigned** Student ID: _____

☐ **Demographics Entered**

☐ **Guidance Counselor/Elementary Attendance**

HOOSICK FALLS CENTRAL SCHOOL DISTRICT
STUDENT EMERGENCY INFORMATION/REGISTRATION FORM

Student Information

Student Name: _____ Student #: _____ Grade: _____

Physical Address: _____ Homeroom #: _____ HR Teacher: _____

_____ Date of Birth: _____ Place of Birth: _____

County of Residence: _____ Gender: _____ Locker #: _____ Locker Combo: _____

Mailing Address: _____ Is student of Hispanic, Latino of Spanish Origin? ☐ Yes ☐ No

(if other than above) _____ Ethnicity: ☐ American Indian ☐ Black/African American

Home Phone Number: _____ **(Choose one)** ☐ Native Hawaiian/ Other Pacific Islander

Home Language (if other than English): _____ ☐ Asian ☐ White ☐ Biracial

Birth Country: _____ Date of 1st Polio Vaccination: _____

Special Accommodations (Please choose all that apply)

_____ None _____ Special Education Classification (IEP) _____ Section 504 Classification

_____ AIS Math _____ AIS Reading _____ Speech

_____ Counseling (please explain) _____ _____ Other (please explain) _____

Every parent/guardian has the right to have their child evaluated for special education services and programs pursuant to applicable Federal and State laws. For more information, please visit: http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

Parent/Guardian Information

LIST ONLY <u>LEGAL</u> PARENT AND/OR GUARDIAN

Parent/Guardian (1):_____ Parent/Guardian (2): _____

Email Address: _____ Email Address: _____

Marital Status: _____ Marital Status: _____

Place of Employment: _____ Place of Employment: _____

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

The District presumes that either parent of the student has the authority to obtain the child's release from school. However, a child shall not be released to a non-custodial parent if the District has been provided with a certified copy of a legally binding instrument, such as a court order or decree of divorce, separation or custody that indicates that the non-custodial parent does not have the right to obtain such release.

Child lives with: (Please circle one) Both Parents Mother Father Other (Specify) Foster Parents Homeless

Other Adult living in home **with supervisory jurisdiction**: _____

Relationship: _____ Place of Employment: _____

Work Phone: _____ Cell Phone: _____

Emergency information

In accordance with Chapter 549 of the Education Law of 1986, I am providing the following list of people to whom my child/children, upon my written authorization, may be released. These people may also be contacted in the event of an emergency and I cannot be reached.

1. Name: _____ Relationship: _____
   Address: _____ Daytime Phone: _____
2. Name: _____ Relationship: _____
   Address: _____ Daytime Phone: _____

Physician to be called in an Emergency: _____

Phone: _____ Hospital Choice: _____

Please attach a list of any allergic reactions or medical problems your child has and indicate what emergency treatment your family doctor has ordered. Please also note any medications your child takes daily at home.

RELEASE

If emergency treatment is required and I, or my other listed emergency contacts, cannot be reached, I permit and allow Hoosick Falls Central School District school authorities to exercise their own judgment to transport my child to a hospital emergency room. I further permit and allow a Hoosick Falls Central School District school physician to complete physical examinations on my child as required by State Law. I understand that my signature below <u>does not</u> allow for the release of confidential information about my child that is protected by Federal Law.

Parent/Guardian Signature: _____ Date: _____

TRANSPORTATION INFORMATION

Student Name _____ **ID #** _____

Parent's Name _____ **Grade** _____

Home Phone # _____

HOME ADDRESS 911 Address	MAILING ADDRESS (if different from 911 address)
_____ Town_____ Zip_____	_____ Town_____ Zip_____

PICKUP: **Put a check (√) where your child is to be picked up each day. If you check other, write the 911 address where your child is to be picked up in the space provided.**

Day of the Week	Home	Other	911 Address of Other
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

DROP-OFF: **Put a check (√) where your child is to be dropped off each day. If you check other, write the 911 address where your child is to be dropped off in the space provided.**

Day of the Week	Home	Other	911 Address of Other
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

HOOSICK FALLS CENTRAL SCHOOL DISTRICT
RECORD RELEASE AUTHORIZATION

STUDENT(S) DATE OF BIRTH GRADE

_____

_____

_____

I hereby give permission for the following school(s) to release records to the Hoosick Falls Central School District:

_____ _____

_____ _____

- Health Records
- Academic Records
- Psychological Evaluations (if available)
- Special Education Records (if available)
- Full disciplinary file

Please release all general education and Special Education records, reports, test data, and health information for the above listed students.

This release may not, in any way, be construed as permission to forward this information to a third party.

<u>All records should be sent to:</u>

Central Registrar
Hoosick Falls Central School District
P.O. Box 192
Hoosick Falls, New York 12090
Telephone: (518) 686-7321 ext. 1510
Fax: (518) 686-9847

_____ _____

Parent/Guardian Signature School District Employee

_____ _____

Date Date

* The attached scholastic records are released to you under allowable provisions of Public Law 93-380 Section 438 under the condition that you will not permit any other party to have access to these records or will not release the information contained therein in personally identifiable form to any other party without the written consent of the student or parent (if student is under 17 years of age and not attending an institution of post-secondary education).

Dental Health Certificate

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

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐Male ☐Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade/Cluster

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐Yes ☐No

Has your child had any previous dental work done? ☐Yes ☐No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam 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 dental condition to be able to attend school and focus on school activities.

No, The student listed above is not in fit condition of dental health to permit him/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to school, parent please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated), a filling, dental trauma, or a tooth extracted? Please explain and give dates of treatment:

_____

☐Yes ☐No **Untreated Caries/Dental Needs –** Does this child have an open cavity? Does this child have any chipped, broken, or missing teeth? Is this child having any pain? Is he/she able to chew and speak?
If the answer is yes, please explain: _____

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. 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.

HOOSICK FALLS CENTRAL SCHOOL DISTRICT
PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL

Prescription and over-the-counter medications cannot be administered to a student without the signatures of both a physician and the person responsible for the child. The medication must be sent to the school in the original bottle, tube or box. Medication sent in any other package or container cannot be administered to the student. New York State and the Hoosick Falls Central School District feel this rule is necessary for the safety of the child.

The parent and the licensed care provider must sign this authorization form.

A. To be completed by parent/legal guardian:

I request that my child _____, grade _____, receive the over-the-counter medication or the prescription medication as described below. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature: _____

Address: _____

Home Phone: _____ Work Phone: _____

Date: _____

B. To be completed by a licensed health care provider:

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

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Prescribed dosage, frequency and route of administration: _____

_____

Time to be taken during school hours: _____

Duration of treatment: _____

Possible side effects and adverse reactions (if any): _____

_____

Other recommendations: _____

_____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

HOOSICK FALLS CENTRAL SCHOOL DISTRICT
ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: Hoosick Falls Central School District

Name of School: Hoosick Falls School (K-12)

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: _____ (mm/dd/yyyy)

Grade: _____ (preschool-12)

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they do not 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 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): _____
  _____
- ☐ In permanent housing

_____ _____

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

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

_____

Date

HOME LANGUAGE QUESTIONNAIRE (HLQ)

Student Name: _____

In order for us to plan an appropriate program for your child, we need to determine how well he/she speaks, understands, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Please place a checkmark in the appropriate box and specify the language if other than English.

---

1. What language(s) are spoken in the student's home or residence? ☐ English ☐ Other _____ Specify

2. What language(s) are spoken most of the time to the student in the home or residence? ☐ English ☐ Other _____ Specify

3. What language(s) does the student understand? ☐ English ☐ Other _____ Specify

4. What language(s) does the student speak? ☐ English ☐ Other _____ Specify

5. What language(s) does the student read? ☐ English ☐ Other _____ Specify
☐ Does Not Read

6. What language(s) does the student write? ☐ English ☐ Other _____ Specify
☐ Does Not Write

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

	Very Well	Only a little	Not at all
Understands English	☐	☐	☐
Speaks English	☐	☐	☐
Reads English	☐	☐	☐
Writes English	☐	☐	☐

HOOSICK FALLS CENTRAL SCHOOL DISTRICT
HEALTH HISTORY
To be completed by Parent/Guardian

Name: _____ Birth Date: _____ Grade: _____

*Please answer **YES** or **NO** for each item. Provide specific information for any **YES** answers on separate sheet.*

Medication Allergy (to what?)	Headache/Migraine
Food Allergy (to what/how severe?)	Head Injury/Concussion
Seasonal/environmental allergies (pets, mold, dust, trees, etc.)	Does your child have an Epipen? Know proper technique for use?
Insect/Bee Sting Allergy	Mononucleosis
Heart Problem/Murmur	Pneumonia
ADD/ADHD	Seizure Disorder
Asthma Has Inhaler? Has Nebulizer Meds?	Strep/frequent sore throat Has your child been seen by an ENT? Allergy Specialist?
Bladder/Kidney Injury/disease/problem	Stomach Problems (reflux, lactose intolerance)
Frequent Colds	Celiac Disease/Gluten Intolerance
Diabetes	Tonsillitis
Ear Infections/Tubes	Developmental Delay
Hearing Loss/Aids	Physical Therapy
Vision/Eye Problems	Speech Therapy
Wear Glasses/Contacts	Any other health condition/concern?
Fracture/Sprain (please list)	Birth Weight: _____lbs _____ozs Normal pregnancy/delivery?
List hospitalizations, Operations, Injuries Date Reason _____ _____	Has your child been to a dentist? Name: Date of last exam: Any dental problems? Braces?
Child's Physician:	

Does your child take any medication(s)? YES ____ NO ____ (if yes, please list name, dosage, and when taken):
_____
_____

Are there any medical, emotional, behavioral or developmental conditions requiring special attention? _____
_____

Is your child receiving counseling services? _____

Parent/Guardian Signature: _____ Date: _____

PLEASE PROVIDE UPDATES AS NECESSARY

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

❒ Immunization record attached
(Immunization record must be attached to this Health Certificate/Appraisal Form)

Sickle Cell Screen: ❒ Positive ❒Negative ❒ Not done Date: _____
PPD: ❒ Positive ❒Negative ❒ Not done Date: _____
Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: _____
Dental Referral ❒ Yes ❒ No ❒ Not done Date: _____

Significant Medical/Surgical History: ❒ See attached _____

Allergies: ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Other: _____
❒ Seasonal ❒ Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: _____

Nutrition: _____ Lungs: _____
Nose: _____ Heart: _____
Spine: _____ Murmur: _____
Dental: _____ Rhythm: _____
Orthodontic: _____ Abdomen: _____
Throat: _____ Hernias: _____
Speech: _____ Genitourinary: _____
Skin: _____ Nervous System: _____

MEDICATIONS

Medications (list all): ❒ None ❒ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: _____ ❒ None

❒ **Known or suspected disability:** _____ ❒ Please monitor

❒ **Restrictions:** _____ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

Registration Checklist – Appendix A

Proof of Residency:

Documentation of proof of residency in the Hoosick Falls Central School District may include:

1. A copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement;
2. A statement by a third-party landlord. owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the district, which may be either sworn or unsworn;
3. Such other statement by a third party relating to the parent(s)' or person(s) in parental relation's physical presence in the district; and/or
4. Pay stub;
5. Income tax form;
6. Utility or other bills;
7. Membership documents (*e.g.,* library cards) based upon residency;
8. Voter registration document(s);
9. Official driver's license, learner's permit or non-driver identification;
10. State or other government issued identification;
11. Documents issued by Federal, State or local agencies (*e.g.,* local social service agency, Federal Office of Refugee Resettlement); or
12. Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers.

The above list is not exhaustive and the District may accept other forms of documentation and/or information establishing physical presence in the district if the suggested documents are not available.

Proof of Age:

A. Where a certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth is available, no other form of evidence may be used to determine a child's age;

B. Where the documentation listed in clause (*a*) of this subparagraph is not available, a passport (including a foreign passport) may be used to determine a child's age; and

C. Where the documentation listed in both clauses (*a*) and (*b*) of this subparagraph are not available, the board of education or its designee may consider certain other documentary or recorded evidence in existence two years or more, except an affidavit of age, to determine a child's age. Such other evidence may include but not be limited to the following:

1. Official driver's license;
2. State or other government issued identification;
3. School photo identification with date of birth;
4. Consulate identification card;
5. Hospital or health records;
6. Military dependent identification card;
7. Documents issued by Federal State or local agencies (*e.g.,* local social service agency, Federal Office of Refugee Resettlement);
8. Court orders or other court-issued documents;
9. Native American tribal document; or
10. Records from non-profit international aid agencies and voluntary agencies.

The above list is not exhaustive and the District may accept other forms of documentation and/or information establishing the student's age if the suggested documents are not available.

Welcome to the Hoosick Falls Central School District! New students moving into the District and students who will be starting kindergarten must register at the Hoosick Falls Central School District office, located at 21187 NY-22, Hoosick Falls, New York 12090. If you relocate to the Hoosick Falls Central School District during the summer, please do not wait until September to register. Our school offices are open during the week throughout the summer. Call and make an appointment to register your child today!

When you come in to register your child, please bring your completed enrollment forms and other requested documents. If you do not currently have the necessary documentation, the Commissioner's Regulations require that the District still enroll your child and permit the child to attend classes on the next school day, or as soon thereafter as practicable. You will be given three business days to produce the requested documentation, after which time the District will review your submitted information and make a residency decision or determination of your possible qualification under the McKinney-Vento Homeless Education Assistance Act. If a determination of non-residency is made, you will be notified in writing. Non-resident students are permitted to attend Hoosick Falls Central School District on a tuition-paying basis, upon the approval of the Board of Education.

The District has updated its enrollment and registration materials to reflect the current state of the law regarding immigration status and the registration process. The District will not inquire into immigration or citizenship status at the time of enrollment; however, after a residency determination has been made certain data may be collected for State and Federal funding purposes.

Questions with regard to the registration process or materials may be directed to: Cathy Conway at conwayc@hoosickfallscsd.org or 518-686-7321 ext. 1510.

Sibling Information

Names	Birth year	Residence, if away from home
Brothers		
Sisters		