

# Catskill Central School District Student Registration Form

**Official Use Only:**

Application Date: \_\_\_\_\_ Student ID #: \_\_\_\_\_ Start Date: \_\_\_\_\_  
 Building: \_\_\_\_\_ Grade: \_\_\_\_\_ FS Bar code: \_\_\_\_\_ Registrar's Initials: \_\_\_\_\_

**STUDENT INFORMATION— Fill out completely & clearly.**

Grade Entering: UPK K 1 2 3 4 5 6 7 8 9 10 11 12

Student's Last Name \_\_\_\_\_ Student's First Name \_\_\_\_\_ Student's Middle Name \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Gender (circle): M F  
 Date of Entry in USA: \_\_\_\_\_ Student's Primary Language: \_\_\_\_\_ Years in US Schools: \_\_\_\_\_

**ETHNICITY: (Check all that apply)**

- Hispanic (1)    
  American Indian/Alaskan Native (2)    
  Black/African American (3)    
  Asian (4)    
  White (5)    
  Native Hawaiian/Pacific Islander (6)

**PARENT/GUARDIAN INFORMATION:**

Parent/ Guardian Last Name \_\_\_\_\_ Parent/Guardian First Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Mailing address (if different from physical address) \_\_\_\_\_ Email address \_\_\_\_\_  
 Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Lives with student  
 Has custody of student  
 Should receive mail  
 Can pick up student  
 Access to parent portal (email address req'd)

Parent/ Guardian Last Name \_\_\_\_\_ Parent/Guardian First Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Mailing address (if different from physical address) \_\_\_\_\_ Email address \_\_\_\_\_  
 Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Lives with student  
 Has custody of student  
 Should receive mail  
 Can pick up student  
 Access to parent portal

**Enter FULL LEGAL name(s) of ALL CHILDREN living in the household.**

Total # of persons living in residence: \_\_\_\_\_

	<u>Name</u>	<u>Relationship to parent/guardian listed</u>	<u>DOB</u>	<u>School</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

**HEALTH INFORMATION:**

Student's Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION— If parent/guardian can not be reached.**

Emergency Contact- Last Name \_\_\_\_\_ Emergency Contact- First Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address (optional) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address (optional) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work \_\_\_\_\_

Lives with student  
 Has custody of student  
 Should receive mail  
 Can pick up student  
 Access to parent portal (email address req'd)

Emergency Contact- Last Name \_\_\_\_\_ Emergency Contact- First Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address (optional) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Email Address (optional) \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work \_\_\_\_\_

Lives with student  
 Has custody of student  
 Should receive mail  
 Can pick up student  
 Access to parent portal (email address req'd)

**IS STUDENT IN FOSTER PLACEMENT?**  Yes  No **DSS 2999 FORM SUBMITTED?**  Yes  No

If yes, Agency: \_\_\_\_\_ Caseworker's Name: \_\_\_\_\_

Agency Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Caseworker Phone Number (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_

**PREVIOUS SCHOOL INFORMATION:**

School Name: \_\_\_\_\_ Last Grade Attended: \_\_\_\_\_ Last Day Attended: \_\_\_\_\_

School Address \_\_\_\_\_ School Telephone Number: \_\_\_\_\_

Has student previously attended Catskill CSD? Yes No If yes, what grade? \_\_\_\_\_

**HAS THE STUDENT EVER RECEIVED ANY OF THE FOLLOWING SERVICES? (Please check all that apply):**

Special Education / Individualized Education Plan (IEP): Yes No

Academic Intervention Services (AIS): Yes No If yes...  ELA  Math  Other: \_\_\_\_\_

English as Second Language Services: Yes No

**EMERGENCY PLAN:** My family has a plan for an emergency early dismissal from school and my child knows where to go if I am not at home at dismissal time. Yes No

It is policy of the Catskill Central School District that all students must provide an ACCEPTABLE PROOF OF RESIDENCY (see list of requirements from the Office of the Registrar) in order to register to attend school. Please be advised that, in the event that a family violates the residency requirement, the Catskill Central School District has the right to bill for back tuition for the period of time that the student(s) attended District schools as non-residents. I certify that I am a resident of the Catskill Central School District.

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

Date \_\_\_\_\_

**From the Office of the Registrar:**

*Welcome to Catskill Central School District*

All new students wishing to register must go to the Registrar's office, located at...

CCSD Superintendent's Office

343 West Main St.

Catskill, NY

518-943-4697 (phone) / 518-719-3028 (fax) / 518-943-7116 (alt. fax)

**Hours of registration:**

**School Year (Sept.- June): 8:30am- 3:30pm (Monday – Friday)**

**Summer (July- Aug.): Please call to schedule an appointment.**

The following documentation(s), along with your completed enrollment packet, are **required** in order to enroll your child for school at Catskill Central School District:

- ⇒ **Proof of Date of Birth** (*birth certificate or passport*)
- ⇒ **Proof of Residency** (*utility bill – gas, oil, electric, telephone, cable rental agreement/lease/receipt*) (*Proof of residency must be in parent/guardian name*)
- ⇒ **Immunization Record / Physician Health & Dental Forms**  
(*Public Health Law 2164 requires the following immunizations be received prior to the child being allowed to enter school*)  
3 DPT            3 Polio            2 Measles            1 Mumps  
1 Rubella            3 Hepatitis            1 Varicella
- ⇒ **Lead Screening** (*Incoming UPK and Kindergarten students only.*)
- ⇒ **Picture I.D. of the Parent/Guardian** (*drivers license*)

Pre-School Student Documentation for families meeting with the Committee on Pre-School Special Education may be submitted at either the Registrars Office or the Special Education Office.

## AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Full Name:	Date of Birth:	Entering Grade:
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*In order to coordinate educational plans for the above named student, I authorize the following accredited school or authorized agency to release the requested information to Catskill Central School District:*

Previous School \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School Phone \_\_\_\_\_ School Fax \_\_\_\_\_

*I understand that such information will be treated as confidential and privileged and used only for the purpose of giving help and guidance to persons working with my son/daughter.*

Signature of Parent/Guardian or Authorized School Representative \_\_\_\_\_ Date \_\_\_\_\_

***For office use only below:***

*I hereby authorize the following checked information, contained in the record of the above named student,*

- Enrollment (start date \_\_\_/\_\_\_/\_\_\_)
- Special Education Referral
- Academic Records/ Official Transcripts
- Attendance Records
- Birth Certificate
- Health/ Medical Records
- Current IEP
- Discipline Records
- Section 504 Plans
- Immunizations
- Psychological Reports
- Standardized Test Scores
- Other \_\_\_\_\_

Please send records to:

- Catskill Elementary School  
770 Embought Rd. Catskill, NY 12414  
(518) 943-0574/ (518) 943-5396 (fax)
- Catskill Middle School Guidance Office  
345 West Main St. Catskill, NY 12414  
(518) 943-5665/ (518) 943-3001 (fax)
- Catskill High School Guidance Office  
341 West Main St. Catskill, NY 12414  
(518) 943-2345/ (518) 943-7470 (fax)
- Catskill Special Education Department  
770 Embought Rd. Catskill, NY 12414  
(518) 943-0574 ext 307 / (518) 943-5397 (fax)
- Office of the Registrar 343 West Main St. Catskill, NY 12414 (518) 943-4697/ (518) 719-0328 (fax)

\*Parental permission is no longer required when records are requested by authorized school personnel (Family Educational Rights and Privacy Act. Final rule on Education Records, Federal Register, June 17, 1976, Vol 41, No. 118, Page 24673)

Student Id Number:		Bus Route:	
Start Date:		Contractor:	



*reflecting educational excellence*

## Request for Transportation

This form should be filled out for all transportation students including special education and students transported outside of the Catskill district. If form is for out of district transportation, forms must be received by April 1<sup>st</sup> for the transportation for the following school year.

Today's Date \_\_\_\_\_

Student's Name \_\_\_\_\_  
First name Last Name

Check if this is a new student  School Attending \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Grade \_\_\_\_\_

Home Phone# (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Cell# (\_\_\_\_) \_\_\_\_\_

Physical Street Address \_\_\_\_\_  
(911 Assigned Address) House Number Street Address

\_\_\_\_\_ Town Zip

Pick up/Drop off Location \_\_\_\_\_

Closest Intersection \_\_\_\_\_

Emergency Dismissal Instructions: (Inclement Weather etc.) \_\_\_\_\_

Completed forms must be forwarded to Bill Muirhead or Tricia Barrett at the Elementary Office and transportation will be set up.

Once the School year has started, this form should be distributed at least four days prior to when transportation is to begin.

# CATSKILL CENTRAL SCHOOL DISTRICT

343 West Main Street  
Catskill, New York 12414

## HEALTH OFFICE SERVICES

The Health Offices at Catskill Central Schools are staffed by Registered Nurses and are open to students during school hours Monday through Friday. (If, at any time, there is not a nurse available the student will return to class or in case of an emergency report to the school office)

Since a student's health can affect his/ her education the health office provides the following services to identify health problems the student may have which may impact on their education.

**Screenings:** **Scoliosis** screening at least once each school year for all students in grades 5 through 9.  
**Vision** screening for all students who enroll in a school of this state including, at a minimum, color perception, distance acuity, near vision, and hyperopia within six months of admission to the school. Distance screening for grades 1,2,3,5,7 & 10.  
**Hearing** screening within six months of admission to the school and in grades Kindergarten, 1, 3, 5, 7 & 10.

**Physicals:** Each new student enrolled in Catskill Schools and for each student entering the 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> and 10<sup>th</sup> grades is to have a satisfactory health examination. We recommend that this examination be completed by the student's personal health care provider.

**All new students entering Catskill School District for the first time are required to show proof of having received a physical by a licensed health care provider within one year of the beginning of the current school year. A Catskill Schools Physical form is attached. If proof is not received your child will be scheduled for an examination with our school physician for the physical.**

**Dental:** At the time of admission to Catskill Schools and in grades Kindergarten, 2, 4, 7 & 10 a dental health certificate to show students current dental health status is also requested.

**Sports Physicals:** All students who participate in sports must have a sports physical completed or approved by our school physician within 1 year of the beginning of the current sports season. No student will be permitted to participate in practice or games unless there is a record of the physical filed in the health office. The sports physical is required annually; however, each student/parent will be required to sign a health update for each sports season. Sports physicals are offered to all students who have not had a physical completed by their private health care provider, three times per year, before each sports season.

**Medications:** Please be reminded that every effort should be made to administer medications at home. If your doctor feels that medication is necessary during the school day then a written request from the students Health Care Provider must be provided to the health office and the medication to be administered must also be in an original container with an original pharmacy label with the student's name on it.

**Students are not allowed to carry medication of any kind on their person (unless cleared by the health office) while in school or participating in school activities.**

**Immunizations:** The school health service maintains records on every student enrolled in the school. A student's health record must indicate that he/she meets the NYS requirements for immunizations in order to attend Catskill schools. **All new students entering grades K-12 must show proof of having the following immunizations:**

**Diphtheria Toxoid containing Vaccine: 3 doses**

**Tetanus Toxoid Containing Vaccine: For children born after 1/1/05 – 3 doses**

**Tetanus, Diphtheria and Pertussis Booster (Tdap) for children born after 1/1/94 & entering grades 6, 7 & 8: 1 dose**

**Polio OPV or IPV: 3 doses**

**Measles: 2 doses, Mumps & Rubella: 1 dose (preferably as MMR)**

**Hepatitis B: 3 doses**

**Varicella: 1 dose if born on or after 1/1/98 or born on or after 1/1/94 and enrolling in grades 6 through 10**

**Emergency Information Form:** Each student will receive an Emergency Information Form on admission and annually, which must be completed and returned to school. It is extremely important that we have the information available for emergency situations.

# New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

Vaccines	Pre-kindergarten (Day Care, Nursery, Head Start, or Pre-K) <sup>2</sup>	School (k-12)
Diphtheria, Tetanus-Containing Vaccine	3 doses (New York City Schools – 4 doses) <sup>3</sup>	3 doses (New York City schools – 4 doses – required for kindergarten only)
Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (DTaP, DTaP)	3 doses if born on or after 1/1/2005	3 doses if born on or after 1/1/2005
Tetanus, Diphtheria, and Pertussis Boosters (Tdap)	Not applicable	Born on or after 1/1/94 and enrolling in grades 6 through 9 for the 2010-2011 school year <sup>5</sup> 1 dose
Polio (IPV or OPV)	3 doses	3 doses
Measles, Mumps and Rubella (MMR)	1 dose	2 doses of measles-containing vaccine and 1 dose each of mumps and rubella (preferably as MMR)
Hepatitis B	3 doses	3 doses <sup>7</sup>
Haemophilus influenzae Type b (Hib)	3 doses if less than 15 months of age or 1 dose administered on or after 15 months of age <sup>8</sup>	Not applicable
Pneumococcal Conjugate Vaccine (PCV)	Born on or after 1/1/08 4 doses by 15 months of age, given at age-appropriate times and intervals <sup>9</sup>	Not applicable
Varicella (Chickenpox)	Born on or after 1/1/2000	Born on or after 1/1/98 or born on or after 1/1/94 and enrolling in grades 6 through 11 for the 2010-2011 school year <sup>6</sup> 1 dose

CATSKILL CENTRAL SCHOOLS  
New Student Health Survey

**HEALTH HISTORY  
TO BE COMPLETED BY PARENT**

Student \_\_\_\_\_ Parent/Guardian \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Family Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

Has your child ever had: (please check)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Ear Problems/Hearing Loss	<input type="checkbox"/> Back Pain/Injury
<input type="checkbox"/> Bee Sting Allergy	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Neck Pain/Injury
<input type="checkbox"/> Asthma	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Fracture
<input type="checkbox"/> Anemia	<input type="checkbox"/> Orthodontic Appliances	<input type="checkbox"/> Dislocation Bones/Joints
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Capped Teeth	<input type="checkbox"/> Knee Pain/Injury
<input type="checkbox"/> Bladder/Kidney Problems	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Joint Sprain/Ligament
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Heart Murmur-Chest Pains	<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Elevated Blood Pressure	<input type="checkbox"/> Injury to Spleen
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Eye Problems/Vision Loss	<input type="checkbox"/> Head Injury/Concussion	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Nose Bleeds Frequent	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Glasses Near Distance	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Tuberculosis

**Please describe, give details & dates of those checked above.**

\_\_\_\_\_

\_\_\_\_\_

Is your child taking medication now? Yes No

Name of medications and dosages:

\_\_\_\_\_

Does your child have any allergies to medications? Yes No  
Please list

\_\_\_\_\_

Type of Reaction:

\_\_\_\_\_

Does your child have any allergies to Bee/Wasp Stings? Yes No

Does your child have any food allergies? Yes No Explain

\_\_\_\_\_

**As per New York State law we will need to have a physician's written prescription, parent written permission to take the medicine in school and medicine in the original container with pharmacy label. The school nurse will dispense medicine per physicians prescribed directive.**

I, the undersigned, clearly understand these questions are asked in order for the school to determine my child's medical needs & adaptations to the school program, when necessary. The answers are correct as of this date.

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Parent/Guardian Signature)

PRINT NAME: \_\_\_\_\_

Catskill Central School District

LICENSED HEALTH CARE PROVIDER PHYSICAL FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

HEALTH HISTORY Complete the following which apply and include dates if possible:

Allergies: \_\_\_\_\_ Mononucleosis: \_\_\_\_\_ Seizure Disorder: \_\_\_\_\_
Asthma: \_\_\_\_\_ Chicken Pox: \_\_\_\_\_
Ear Conditions \_\_\_\_\_ Vaccine Preventable Disease \_\_\_\_\_ Other \_\_\_\_\_
Colds/Sore Throats \_\_\_\_\_ Injuries \_\_\_\_\_
Rashes/Eczema \_\_\_\_\_ Diabetes \_\_\_\_\_
Pneumonia \_\_\_\_\_ Heart Murmur \_\_\_\_\_ Surgery \_\_\_\_\_

EXAMINATION

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_ P: \_\_\_\_ R: \_\_\_\_\_
Hearing Rt: \_\_\_\_\_ Lt: \_\_\_\_\_
Vision: Rt: \_\_\_\_\_ Lt: \_\_\_\_\_ c correction? \_\_\_\_\_
General Appearance \_\_\_\_\_ Thorax \_\_\_\_\_
Skin \_\_\_\_\_ Size, Shape, Symmetry \_\_\_\_\_
Nutrition \_\_\_\_\_ Breast \_\_\_\_\_
Lymph Glands \_\_\_\_\_ Lungs \_\_\_\_\_
Head \_\_\_\_\_ Abdomen \_\_\_\_\_
Ears \_\_\_\_\_ Hernia \_\_\_\_\_
Tympanic Membranes \_\_\_\_\_ Liver, Spleen, Kidney \_\_\_\_\_
Eyes \_\_\_\_\_ Genitalia \_\_\_\_\_
EOM/Pupils \_\_\_\_\_ Male: Testes/Penis \_\_\_\_\_
Nose \_\_\_\_\_ Pubertal Changes (Tanner) \_\_\_\_\_
Mouth \_\_\_\_\_ Female: Menses \_\_\_\_\_
Teeth/Gums \_\_\_\_\_ Pubertal Changes (Tanner) \_\_\_\_\_
Throat \_\_\_\_\_ Skeletal \_\_\_\_\_
Tonsils \_\_\_\_\_ General (Posture/Gait) \_\_\_\_\_
Neck \_\_\_\_\_ Spine (Scoliosis) \_\_\_\_\_
Thyroid \_\_\_\_\_ Joints, Range of Motion \_\_\_\_\_
Cardiovascular \_\_\_\_\_ Extremities \_\_\_\_\_
Rhythm \_\_\_\_\_ Neurologic \_\_\_\_\_
Murmur \_\_\_\_\_ Speech \_\_\_\_\_
Pulses \_\_\_\_\_ Coordination/Reflexes \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

RESULTS OF SPECIAL TESTS: \_\_\_\_\_

ACTIVITY RESTRICTIONS: \_\_\_\_\_

SPECIAL CONDITIONS: \_\_\_\_\_

APPROVED FOR WORKING PAPERS?  - YES  - NO

M.D. NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ Date of Physical: \_\_\_\_\_
(print name)

ADDRESS: \_\_\_\_\_ TELEPHONE #: (\_\_\_\_) \_\_\_\_\_

PLEASE ATTACH A COPY OF THIS STUDENTS IMMUNIZATION RECORD SO THAT WE MAY UPDATE THE SCHOOL RECORD.

**Catskill Elementary School**  
770 Embought Road  
Catskill, NY 12414  
(518)943-0574  
Fax: 943-5396

**Catskill Middle School**  
345 West Main Street  
Catskill, NY 12414  
(518)943-5665  
Fax: 943-4899

**Catskill High School**  
341 West Main Street  
Catskill, NY 12414  
(518)943-2300  
Fax: 943-4899

School Health Services



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

Dear Parent or Guardian:

A physical examination is required for students in Pre-kindergarten or Kindergarten and in Grades 2, 4, 7 and 10. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

After September 1<sup>st</sup>, 2009, your child will be required to have a physical examination and a dental examination. A certificate is attached to take to your child's dentist. This certificate should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

For a listing of area Dental Clinics please call Greene County Public Health and Children's Services at 518-719-3600.

Thank you for your cooperation. Our students benefit when we work together to promote good health to support their academic achievement.

Please call your child's principal if you have any questions or concerns.

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*Principal*

## 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: / / Sex:  Male  Female Will this be your child's first visit to a dentist?  Yes  No  
Month Day Year

School: Name Grade

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

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

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

Parent's Signature Date

### Section 2. To be completed by the Dentist

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

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

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

Optional Sections - If you agree to release this information to your child's school, please initial here.  

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

- Yes  No **Caries Experience/Restoration History** - Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries** - Does this child have an open cavity? [At least 1/4 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): \_\_\_\_\_

#### 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.

# RESIDENCY QUESTIONNAIRE

Name of LEA (to be filled out by District): \_\_\_\_\_

Name of School: Catskill Central School District

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

Gender:  Male  Female Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_ ID#: \_\_\_\_  
Month Day Year (preschool-12) (optional)

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 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 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 (Rent, lease, or own physical residence)

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

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

\_\_\_\_\_  
Date

Please fill out this form completely. If there are any questions, please feel free to contact your McKinney-Vento liaison at (518) 943-4697 ext. 1418 or (518) 943-0574 ext. 334.



## 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?
 

<input type="checkbox"/> English	<input type="checkbox"/> Other _____	<i>specify</i>
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- What language(s) are spoken most of the time to the student, in the home or residence?
 

<input type="checkbox"/> English	<input type="checkbox"/> Other _____	<i>specify</i>
----------------------------------	--------------------------------------	----------------
- What language(s) does the student understand?
 

<input type="checkbox"/> English	<input type="checkbox"/> Other _____	<i>specify</i>
----------------------------------	--------------------------------------	----------------
- What language(s) does the student speak?
 

<input type="checkbox"/> English	<input type="checkbox"/> Other _____	<i>specify</i>
----------------------------------	--------------------------------------	----------------
- What language(s) does the student read?
 

<input type="checkbox"/> English	<input type="checkbox"/> Other _____	<input type="checkbox"/> Does Not Read
	<i>specify</i>	
- What language(s) does the student write?
 

<input type="checkbox"/> English	<input type="checkbox"/> Other _____	<input type="checkbox"/> Does Not Write
	<i>specify</i>	
- 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:

### 2011-2012 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and return it to Brenda Lubera. Call (943-2300X2124) if you need help. Additional names may be listed on a separate paper.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. Food Stamp or TANF Benefits:

If anyone in your household receives either food stamp, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: \_\_\_\_\_ CASE # \_\_\_\_\_

3. If any child you are applying for is homeless, migrant or a runaway, please call this number: \_\_\_\_\_

Homeless    Migrant    Runaway

(Homeless Liaison/Migrant Education Coordinator)

4. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions <i>Amount / How Often</i>	Child Support, Alimony <i>Amount / How Often</i>	Pensions, Retirement Payments <i>Amount / How Often</i>	Other Income, Social Security <i>Amount / How Often</i>	No Income <input checked="" type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

5. Signature: An adult household member must sign this application and provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before it can be approved.

I certify (promise) that all of the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

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

Email Address: \_\_\_\_\_ Last Four Digits of Social Security Number: \*\*\*-\*\*-\_\_\_\_

I do not have a SS#

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Address \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE - FOR SCHOOL USE ONLY**

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)  
 Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

- Food Stamp/TANF/Foster
- Income Household: Total Household Income/How Often: \_\_\_\_\_ / \_\_\_\_\_ Household Size: \_\_\_\_\_
- Free Meals    Reduced Price Meals    Denied/Paid    Temporary Free 45 Days Expires \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Notice Sent: \_\_\_\_\_ Signature of Reviewing Official \_\_\_\_\_

## APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, submit a Direct Certification letter received from the Office of Temporary and Disability Assistance OR complete only one application for your household using the instructions. Sign the application and return the application to \_\_\_\_\_. If you have a foster child in your household, you may include them on your application. A separate application is no longer needed. Call the school if you need help: \_\_\_\_\_. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

**PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.**

- (1) Print the names of the children, including foster children, for whom you are applying on one application.
- (2) List their grade and school.
- (3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

**PART 2 HOUSEHOLDS GETTING FOOD STAMPS, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 5.**

- (1) List a current Food Stamp, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
- (2) An adult household member must sign the application in PART 5. SKIP PART 4. Do not list names of household members or income if you list a food stamp case number, TANF or FDPIR number.

**PART 3 Before completing an application for a child who may be homeless, a migrant education student, or a runaway, please call your school's homeless liaison or migrant education coordinator at this number:**

*(Homeless Liaison/Migrant Education Coordinator name and Phone Number)*

**PARTS 4 & 5 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 5.**

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
- (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
- (3) The application must include the last four digits only of the social security number of the adult who signs **PART 5** if Part 4 is completed. If the adult does not have a social security number, check the box. If you listed a food stamp, TANF or FDPIR number, a social security number is not needed.

**OTHER BENEFITS:** Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). In order to determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

### PRIVACY ACT STATEMENT

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We **MAY** share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

### DISCRIMINATION COMPLAINTS

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."