

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: _____

Name	Relationship to parent/guardian listed	DOB	School
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 _____ (____) _____ ext. _____ Caseworker Phone Number _____

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,

- | | |
|---|---|
| <input type="checkbox"/> Enrollment (start date ___/___/___) | <input type="checkbox"/> Special Education Referral |
| <input type="checkbox"/> Academic Records/ Official Transcripts | <input type="checkbox"/> Attendance Records |
| <input type="checkbox"/> Health/ Medical Records | <input type="checkbox"/> Current IEP |
| <input type="checkbox"/> Section 504 Plans | <input type="checkbox"/> Immunizations |
| | <input type="checkbox"/> Standardized Test Scores |
| | <input type="checkbox"/> Birth Certificate |
| | <input type="checkbox"/> Discipline Records |
| | <input type="checkbox"/> Psychological Reports |
| | <input type="checkbox"/> Other _____ |

Please send records to:

- | | |
|---|--|
| <input type="checkbox"/> Catskill Elementary School
770 Embought Rd. Catskill, NY 12414
(518) 943-0574/ (518) 943-5396 (fax) | <input type="checkbox"/> Catskill Middle School Guidance Office
345 West Main St. Catskill, NY 12414
(518) 943-5665/ (518) 943-3001 (fax) |
| <input type="checkbox"/> Catskill High School Guidance Office
341 West Main St. Catskill, NY 12414
(518) 943-2345/ (518) 943-7470 (fax) | <input type="checkbox"/> Catskill Special Education Department
770 Embought Rd. Catskill, NY 12414
(518) 943-0574 ext 307 / (518) 943-5397 (fax) |
| <input type="checkbox"/> 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 1st 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 2nd, 4th, 7th and 10th 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/Attendance¹

Vaccines	Pre-kindergarten (Day Care, Nursery, Head Start, or Pre-K) ²	School (k-12)
Diphtheria, Tetanus, and Pertussis (DTaP)	3 doses (New York City Schools – 4 doses) ³	3 doses (New York City schools – 4 doses – required for kindergarten only) 3 doses if born on or after 1/1/2005
Tetanus Toxoid, Diphtheria, and Pertussis (Tdap) and Pertussis Vaccine (DTaP-Boost)	3 doses if born on or after 1/1/2005	3 doses if born on or after 1/1/2005
Tetanus, Diphtheria, and Pertussis Booster (Tdap)	Not applicable	Born on or after 1/1/94 and enrolling in grades 6 through 9 for the 2010-2011 school year ⁴ 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 ⁷
Influenza (Influenza type A (H1N1))	3 doses if less than 15 months of age or 1 dose administered on or after 15 months of age ⁸	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 ⁵	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 ¹⁰ 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: _____ (print name) SIGNATURE: _____ Date of Physical: _____

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 1st, 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.

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 1/2 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? 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

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 | <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 <input checked="" type="checkbox"/>	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"/>
			<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 Amount / How Often	Child Support, Alimony Amount / How Often	Pensions, Retirement Payments Amount / How Often	Other Income, Social Security Amount / How Often	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."

Background Information and Developmental History
Catskill Elementary Universal Pre-K

Child's Name: _____ Date of Birth: _____

****All students must be toilet trained prior to September entrance****

The purpose of securing this information about your child is to help the Pre-K staff better understand and provide for the needs of your child. Your child's care during the day is a responsibility we share.

1. Please describe the person(s) or program(s) that has provided care for your child until now.

2. Most young children are afraid of some things. Please state your child's fears, if any. (For example: the dark, animals, sirens, being left somewhere without family, loud noises, crying etc.)

3. Please describe your child's favorite activities, foods, and recreational past times.

4. Does your child have any habits, needs, and or schedules you feel we should know about in attempting to personalize our approach? If so, please describe.

5. Does your child have to be reminded to go to the bathroom? ____ Yes ____ No

6. What word is used for urination? _____

7. What word is used for bowel movement? _____

UPK Background and Developmental History

8. Does your child have any special problems that would affect the school experience? (allergies, handicaps, etc.)

9. Does your child have neighborhood playmates? Yes No

What are their ages? _____

10. How well does your child get along with other children?

11. My child's favorite play activity is: _____

12. My child's favorite toy is: _____

13. Does your child have a pet? Yes No

14. If yes, what kind of pet? _____

15. Is your child hungry at mealtimes? Yes No

16. Name the food(s) your child dislikes:

17. Please check next to the word that best describes your child's characteristic behavior:

Calm

Excitable

Whining

Crying

Happy

Quiet

Active

Cheerful

Cooperative

Easily Angered

Independent

Wants own way

Fights often

Gives in easily

Stubborn

Temper Tantrums Other: _____

UPK Background and Developmental History

18. What type of behavior does your child exhibit that you consider most difficult to deal with?

19. Describe home discipline use by:

Mother: _____

Father: _____

20. What frustrates or upsets your child?

21. Does your child have difficulties speaking? _____ Yes _____ No

22. Does your child dress her/himself? _____ Yes _____ No

23. What age did your child begin talking? _____

24. How often do you read to your child? _____

25. Does your child run away in public places? _____ Yes _____ No

26. Do you have any special talents, skills or interests to share with the Pre-K program?

