CHITTENANGO CENTRAL SCHOOLS

Phone (315) 687-2854
Fax (315) 687-2851

1732 Fyler Road
Chittenango, NY 13037

STUDENT REGISTRATION FORM

Date _____ **Grade** _____ **Bldg** _____

Student Name _____ **Date of Birth** _____
(Last, First, Middle)

Gender M F **Age** _____

Is this student a foster child? Y N If yes, DSS2999 form required

Address Information

Student's Address _____

City, State, Zip _____ Student's Home Phone _____

Date Moved In (mm/dd/yyyy) _____

Is this address a temporary living arrangement? Y N

If address is temporary, is this due to loss of housing or economic hardship? Y N

Please list all siblings living in the home (include pre-school aged children)

Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)	Grade Level

Name, address, and phone number of last school attended

Last School's Name _____ Grade _____

Address _____ Phone _____

Has student previously attended school in NYS? Y N

Has student previously attended Chittenango CSD? Y N

Has child been retained? Y N If yes, what grade? _____

Is child receiving special education services or other educational services? Y N

Dominant Language spoken in the home

☐ English	☐ Russian	☐ Spanish
☐ Portuguese	☐ German	☐ French
☐ Chinese	☐ Dutch	☐ Japanese
☐ Other (please specify):		

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PARENT/GUARDIAN INFORMATION FORM

Parent/Guardian Information (PARENT 1 WILL BE CONTACTED FIRST)		
Parent 1 Name (Last, First)	Has Custody? ☐	Student Lives With? ☐
Relationship to Student	Pick up from School? ☐	Receives Mailings? ☐
Physical Address		
Address	Home Phone	
City, State, Zip	Cell Phone	
E-mail address		
Mailing Address (if different from physical address)		
Mailing Address		
Mailing City, State, Zip		
Employer		
Occupation	Work Phone	
Notes		

Parent/Guardian Information (PARENT 2 WILL BE CONTACTED SECOND)		
Parent 2 Name (Last, First)	Has Custody? ☐	Student Lives With? ☐
Relationship to Student	Pick up from School? ☐	Receives Mailings? ☐
Physical Address (if same as parent 1, please check box) ☐		
Address	Home Phone	
City, State, Zip	Cell Phone	
E-mail address		
Mailing Address (if different from physical address)		
Mailing Address		
Mailing City, State, Zip		
Employer		
Occupation	Work Phone	
Notes		

EMERGENCY CONTACTS FORM

CHITTENANGO CENTRAL SCHOOLS
1732 Fyler Road
Chittenango, NY 13037

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WE WILL CONTACT PARENTS 1 & 2 FIRST. IN THE EVENT THAT PARENTS CANNOT BE REACHED, PLEASE LIST EMERGENCY CONTACTS IN THE ORDER YOU WANT THEM CALLED.

Emergency Contacts		
Contact 3 Name (Last, First)	Has Custody? ☐	Student Lives With? ☐
Relationship to Student	Pick up from School? ☐	Receives Mailings? ☐
Physical Address		
Address	Home Phone	
City, State, Zip	Cell Phone	
E-mail address	Work Phone	
Notes		

Emergency Contacts		
Contact 4 Name (Last, First)	Has Custody? ☐	Student Lives With? ☐
Relationship to Student	Pick up from School? ☐	Receives Mailings? ☐
Physical Address		
Address	Home Phone	
City, State, Zip	Cell Phone	
E-mail address	Work Phone	
Notes		

Sitter Information (Chittenango District Only - Transportation Purposes)	
Sitter Name (Last, First)	Phone
Address	
Pick up Address (**TO SCHOOL**) (Please designate days)	
Drop off Address (**FROM SCHOOL**) (Please designate days)	

Parent/Guardian Signature	**Date**
Print Name	

CHITTENANGO CENTRAL SCHOOL

Michael Eiffe, Superintendent

District Offices
1732 Fyler Road
Chittenango, New York 13037-9520
Fax (315) 687-2851

Jason P. Clark
Assistant Superintendent
for Instructional Services
Telephone (315) 687-2854

RESIDENCY QUESTIONNAIRE

Name of LEA: **Chittenango Central School**

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female ☐ Non-Binary Date of Birth: ____/____/____ *Month Day Year* Grade: ____ *(preschool-12)* ID#: _____ *(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

Date family moved into temporary housing: _____

School district of attendance where last enrolled: _____

Address prior to moving into temporary housing: _____

_____ _____

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

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

_____

Date

CHITTENANGO CENTRAL SCHOOL

Student Racial and Ethnic Identification

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School:

School District Student Identification Number:

Date of Birth (Month/Day/Year)
/ /

Student Name: Last, First, Middle:

Grade Level:

DIRECTIONS TO PARENT/GUARDIAN
PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. (For question (1) Check (√) the box that best describes your child.) Check (√) only ONE box.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

2. Select one or more races from the following five racial groups. [For question (2) Check (√) all groups that apply to your child; check (√) at least ONE box]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition; e.g., Cherokee, Mohawk, Inuit.

☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK:** A person having origins in any of the black racial groups of Africa.

☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ _____

Signature of Parent/Guardian/Other Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify):_____

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations

Revised 2/3/10

CHITTENANGO CENTRAL SCHOOL

Student Racial and Ethnic Identification

To the Parent/Guardian: The Chittenango Central School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Chittenango Central School District in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance, and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (√) in the box for the category or categories which best describe your child. The Chittenango Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete the form on the reverse side of this page

CHITTENANGO CENTRAL SCHOOL

Michael Eiffe, Superintendent

District Offices
1732 Fyler Road
Chittenango, New York 13037-9520
Fax (315) 687-2851

Jason P. Clark
Assistant Superintendent
for Instructional Services
Telephone (315) 687-2854

REQUEST FOR STUDENT RECORDS

Student's Name_____ Date_____

Grade_____ Date of Birth_____

Previous School:_____

Previous School Address:_____

School's Phone #:_____ School's Fax #:_____

The above named student has enrolled in our district. To ensure proper placement, please forward copies of the information outlined below and any other pertinent educational records. Information should be directed to the person listed below. Please call if there are immediate special considerations that we should know.

1. Health and Immunization Records, including last physical exam
2. Last Report Card and Schedule
3. Test Data – including all Academic Intervention Services
4. Attendance Record
5. Discipline Record, Transcripts, Exit Grades, Assessments, Science Labs (if applicable)
6. Special Education Records including last psychological, social history, IEP, and evaluations (speech/language, occupational/physical therapy, psychiatric)

Please forward all information to the following:

☐ Ms. Melissa Stanek, Principal
Bridgeport Elementary School
9076 North Road
Bridgeport, NY 13030
Phone: (315) 687-2280
Fax: (315) 687-2281

☐ Ms. Kara May, Principal
Bolivar Road Elementary School
6983 Bolivar Road
Chittenango, NY 13037
Phone: (315) 687-2880
Fax: (315) 687-2881

☐ Mr. Benjamin New, Director of
Special Education & Pupil
Personnel Services
Chittenango Central Schools
1732 Fyler Road
Chittenango, NY 13037
Phone: (315) 687-2844
Fax: (315) 687-2851
Email: sreid@chittenangoschools.org

☐ Counseling Center
Chittenango Middle School
1732 Fyler Road
Chittenango, NY 13037
Phone: (315) 687-2806
Fax: (315) 687-2801
Email: keverett@chittenangoschools.org

☐ Counseling Center
Chittenango High School
150 Genesee Street
Chittenango, NY 13037
Phone: (315) 687-2911
Fax: (315) 687-2919

I hereby give my permission to release all information to the above checked school(s).

_____
Parent/Guardian

Revised August 14, 2024

CHITTENANGO CENTRAL SCHOOL

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Assistant Superintendent
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DISCIPLINE STATUS ENROLLMENT FORM

Student Name_____

Address_____

Parent/Guardian_____

Telephone_____ ☐ Home _____ ☐ Cell

School Student Last Attended_____

Address of Previous School_____

_____

Phone Number of Previous School_____

Current Discipline Status of Student Seeking Enrollment

Please check all that apply:

☐ Student **is not currently** suspended or expelled from any school and does not have a pending suspension or expulsion recommendation.

☐ Student has been short-term suspended for 10 days or less._____
_____
_____

☐ Student has been **recommended** for long-term suspension (more than 10 days) and recommendation is currently pending. Describe the offense, name of school, and the proposed beginning date and ending date of the suspension/expulsion._____
_____
_____

☐ Student has been long-term suspended (more than 10 days) and is currently **serving** the term of suspension or expulsion. Describe the offense, name the school, and beginning and ending dates of the suspension/expulsion.
_____
_____
_____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
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 in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
Month	*Day*	*Year*
		❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 *specify*	❑ Parent 2 *specify*		
	❑ Guardian(s) *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write	

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School: *Address:*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** *No* *Not sure*
❑ ❑ ❑ *If yes, please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been ***referred*** for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever ***received*** any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

CHITTENANGO CENTRAL SCHOOL
HEALTH & DEVELOPMENT QUESTIONNAIRE

LAUREN KNUTH, R.N.	BOLIVAR RD. ELEMENTARY	687-2886	FAX: 687-2881
TRACY BIEDERMANN, R.N.	BRIDGEPORT ELEMENTARY	687-2276	FAX: 633-5606
LILIANA MONDRICK, R.N.	CHITTENANGO MIDDLE SCHOOL	687-2810	FAX: 687-2801
SABRINA TUCKER, R.N.	CHITTENANGO HIGH SCHOOL	687-2916	FAX: 687-2919

To Parents:

This information is used in the School Health Program to promote and maintain student health. It will be entered on the health record and is confidential. Please complete both sides.

Student's Name_____ Sex M F Place of Birth_____

Date of Birth _____ Home Address _____Home Phone _____

Native Language Spoken In Home_____Second Language Spoken In Home_____

Parent/Guardian's Information

Parent/Guardian Name_____

Home Phone # _____ Cell Phone # _____

Place of Employment _____ Work Phone #_____

Parent/Guardian's Information

Parent/Guardian Name _____

Home Phone # _____ Cell Phone # _____

Place of Employment _____ Work Phone #_____

IMPORTANT

Should your home, work or emergency numbers change, please notify the school office immediately! Your child's health depends upon your support and cooperation in this matter.

Name of Student's doctor _____

Date of **last complete physical examination** _____

PLEASE COMPLETE BOTH SIDES

CHITTENANGO CENTRAL SCHOOL
HEALTH & DEVELOPMENT QUESTIONNAIRE

Medical History – Give Age & Any Related Details

Allergies _____

Asthma _____

Bee/Insect Sensitivity _____

Diabetes _____

Earaches/Hearing Problems _____

Fractures _____

Frequent Stomach Aches _____

Headaches/Migraines _____

Nosebleeds _____

Rheumatic Fever _____

Seizures _____

Toileting Problems _____

Tuberculosis _____

Vision Problems _____

Wears Glasses _____Yes _____ No

Is Any Medication Given Regularly At Home _____Yes _____ No

If Yes, for what problems? _____

Name of Medication_____ Dosage_____ When Given_____

Any Other Serious Illness or Accidents?_____

Surgery? (Dates)_____

Are there any other health issues, which might affect school performance? Attendance?

_____

_____

Chittenango CSD
Committee on Special Education
1732 Fyler Road
Chittenango, NY 13037

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Edncation and Related Services

This form has been adapted from the U.S. Department of Education's model Notification Form[1].

INTRODUCTION

You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district/county to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district (or, for preschool students, the county) to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district or county can ask you to provide consent to check with the New York State Department of Health whether your child has public benefits or insurance (e.g., Medicaid coverage and/or a Client Identification Number (CIN)), and to access these benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. Whether or not you provide consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT

34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)

Before your school district (or for preschool students, your county) can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time.

This consent requirement has two parts.

1 For the full Suggested Model for Written Notification of Parental Rights regarding Use of Public Benefits or Insurance developed by the U.S. Department of Education, see: http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/accmodelwrittennotification-6-11-13.pdf

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing (sharing) personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the school district will (1) identify the records (or information) about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

2. Consent to check with the New York State Department of Health whether your child has a CIN/public benefits or insurance (Medicaid) coverage, and bill your child's public benefits or insurance (Medicaid) program: Your consent must include a statement specifying that you understand and agree that your school district or county, for preschool, may use you or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS
34 CFR §300.154(d)(2)(i)-(iii) and 8 NYCRR §200.5(b)(8)(ii)(b)-(d)

The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for or enroll in a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.

3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:
   a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;
   b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;
   c. increase your premium or lead to the cancellation of your public benefits or insurance; or
   d. cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district or county, for the provision of preschool special education, to use your or your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see:
http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parentalconsent.htm

Please fill in your and your child's names & sign the bottom of the form even if you DO NOT have MEDICAID. This form will stay in your child's file, and will only be used if/when your child receives special education services.

Chittenango CSD
Committee on Special Education
1732 Fyler Road
Chittenango, NY 13037 (315-687-2844)

Medicaid Consent

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____,
(print name of parent/guardian) ***(please print name of child)***

have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Medicaid CIN # ☐☐☐☐☐☐☐☐☐ **Or Initial here: _____ My Child is NOT Eligible for Medicaid.**

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

PARENTS AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. To be completed by parent or guardian

I request that my child, _____, grade ____ receive the medication as prescribed by our licensed health care provider. The medication is to be furnished by me in the properly labeled, original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Grades 6-12: May self-administer and carry on self _____

Signature (Parent/Guardian) _____
Address: _____
Telephone: Home _____ Work _____ Cell _____
Date _____

B. To be complete by the licensed health care provider:

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

Name: _____Birth Date: _____
Diagnosis: _____
Name of Medication: _____
Prescribed Dosage, Frequency and Route of Administration: _____
_____
_____
_____
Time Medication is to be Taken During School Hours _____
Duration of Treatment _____
Possible Side Effects and Adverse Reactions (if any) _____
_____
_____

Can this Student self-medicate and carry on self? Yes _____ No _____

Name of Licensed Provider and Title (Please Print) _____
_____
Date _____

Community Eligibility Provision (CEP)/Provision 2 non-base year
Household Income Eligibility Form

Chittenango Central Schools is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call 315-687-2847, if you need help.

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

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: ______________________________ CASE # ______________________

3. 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). Do not leave income blank. If no income, check box. 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
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐
	$ ____ / ____	$ ____ / ____	$ ____ / ____	$ ____ / ____	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive 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:

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

SNAP/TANF/Foster Income   Total Household Income/How Often: Household Size:

Free Eligibility   Reduced Eligibility   Denied Eligibility

Signature of Reviewing Official

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

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

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(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 SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.**

(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) 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 form in PART 4. **SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4 — **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living 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. If no income, check the box.** 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.