Student Registration Form

Date: _____

Child's name: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: Mo: ____ Day: _____ Year: _____ **Place of Birth:** _____

Gender: (please check) Male ☐ Female ☐

Ethnicity: Please circle all appropriate selections	Hispanic or Latino (Y/N):	American Indian/Alaskan Native	Asian	AfrAm/Black	Native Hawaiian/Other Pacific Islander	White

Special Services

Is this student receiving any of the following: (Please check)

Resource Room	☐	Speech	☐
Physical Therapy	☐	Occupational Therapy	☐
Remedial Reading	☐	Gifted/Talented Program	☐
Remedial Math	☐		

Father's Name	**Address**	**Phone**
Mother's Name	**Address**	**Phone**
Legal Guardian	**Address**	**Phone**

Day/Month/Yr Moved into Present Address: Month ____ Day _____ Year _____

Is this current address a temporary living arrangement? Yes ☐ No ☐

If yes, is this temporary arrangement due to loss of housing or economic hardship? Yes ☐ No ☐ yes

Was this student HomeSchooled? Yes ☐ No ☐ **If yes, date student was last HomeSchooled:** _____

Do You Have Legal Custody of this Student: Yes ☐ No ☐

Is This Student a Foster Child: Yes ☐ No ☐ **Date Placed** _____

Has this Student attended Cortland Schools: Yes ☐ No ☐ **When** _____

Dominant Language spoken in the home: English ☐ **Other:** _____

Father's Education _____ **Mother's Education** _____

Father's Employment _____ **Mother's Employment** _____

Work Phone _____ **Work Phone** _____

Person to Contact in Emergency (other than above)

Name _____ **Phone** _____

Address _____ **Relationship** _____

Please List Siblings: (living in the home, school age and younger)

Name	Date of Birth	Grade

Please List Babysitter Information if Applicable

Babysitter Name _____

Babysitter Address _____

Babysitter Phone _____

Student Health Information

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

Immunizations: Please provide (Mo/Day/Yr) and Proof (Doctor or Clinic Records)

Oral Polio #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

DPT #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

MMR #1 _____ #2 _____ **Tetanus** _____ **HIB** _____

Tine Test _____ **Results** _____ **Lead Screening** _____ **Results** _____

HepB #1 _____ #2 _____ #3 _____
Varicella #1 _____ **(Immunization)** **Date of Disease:** _____

History of Illness: Indicate year in which child had any of the following diseases or conditions

Anemia	_____	**Heart Disease**	_____	**Scarlet Fever**	_____	**Chicken Pox**	_____
Measles	_____	**Tuberculosis**	_____	**Diabetes**	_____	**Mumps**	_____
Epilepsy	_____	**Contact TBC**	_____	**Kidney/Urine Problem**	_____	**Whooping Cough**	_____
German Measles	_____	**Pneumonia**	_____	**Chest X-Ray**	_____	**Operations**	_____
Ear Cond.	_____	**Serious Injuries**	_____	**Hepatitis**	_____	**Sore Throat**	_____
Frequent Colds	_____	**Asthma**	_____	**Concussion**	_____	**Rheumatic Fever**	_____
Skin Cond.	_____	**Allergic to: (please check)**	**Bee Sting** ☐ **Food** ☐		**Medication** ☐ **Environment** ☐		

Is your child on any medications/if so please provide name and dosage? _____

Please describe any current medical conditions or other concerns in the space below:

_____

Has your child ever been seen by a doctor or emergency room for a head injury? **Y** ☐ **N** ☐

Did the child ever lose consciousness? **Y** ☐ **N** ☐

After the injury did the child experience problems such as: difficulty concentrating, remembering, reading, writing, calculating, poor judgement, changes in getting along with others, etc? (Please explain below)

_____

Does the child have any other significant illnesses such as (brain tumor, cancer, meningitis, encephalitis, leukemia, etc.? _____

Complete the following for incoming kindergarten students only

Were there any unusual circumstances during pregnancy or birth? Please give problem: _____

Birth Weight	_____	**Forceps Used**	_____	**Caesarian Section**	_____	**Prolonged Labor**	_____	**Incubator at Birth**	_____

At what age did your child sit unsupported? _____ **Crawl** _____ **Feed Self** _____

Is your child right or left handed? _____ **Does your child have any special fears or habits?** _____

Has your child ever been hospitalized overnight? (why) _____

Pediatrician _____ **Pediatrician Phone** _____

Dentist _____ **Dentist Phone** _____

Cortland Enlarged City School District

Dear Parent or Guardian,

New York State Education Law requires a physical examination of children when they:

- Enter the school district for the first time (including all Kindergarten students)
- Are in grades 2, 4, 7, and 10
- Participate in interscholastic sports (require yearly physical)
- Need working papers
- Are referred by/to the Committee on Special Education
- Are deemed necessary by school authorities to determine a child's education program

Your family doctor can best evaluate your child's health. He/She can also provide any needed treatment or referrals. The health form, which your doctor completes, becomes part of your child's student health record.

Examinations can be obtained in school. If you prefer the school exam, please indicate below. If we do not receive the completed health form from your doctor, your child will be added to the group of school exams.

At this time, New York State is also requesting a Dental Health Certificate on all new entrants and students in grades K, 2, 4, 7, and 10. Attached is the certificate to be completed by your child's dentist. Please return this form to the school nurse.

Please feel free to call your school nurse if you have a question.

☐ I will take my child to our own doctor. Please provide me with the necessary forms.

☐ I want my child to have a school physical. I expect to be informed of any possible problems, and realize that the school does not provide treatment for any health conditions.

Child's Name: _____

Grade: _____

School: _____

_____
Parent's Signature

_____
Date

CORTLAND CITY SCHOOL DISTRICT
ONE VALLEY VIEW DRIVE
CORTLAND, NEW YORK 13045-3297

FAX: 607-758-4109
PHONE: 607-758-4106
E-MAIL awingard@cortlandschools.org

ANNE M.WINGARD
STUDENT REGISTRATION
WEBSITE: WWW.CORTLANDSCHOOLS.ORG

Date: _____

To: _____ (Name of school transferring from)

_____ (School Address)

_____

_____

According to the Final Regulations-Family Education Rights and Privacy Act (Buckley Act), dated June 17, 1977, it is no longer necessary to obtain written consent to release records between schools. It states that school officials, including teachers within the educational institution and officials of other schools in school systems in which they intend to enroll, may receive a student's records without written consent for such release.

The following student(s) have registered in our school district today:

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

Please send any and all academic and health records you may have for this student to:

Central Registration Clerk
Kaufman Center
1 Valley View Drive
Cortland, New York 13045-3297

Please send all Committee on Special Education and/or psychological records to:

Director of Special Education
Kaufman Center
1Valley View Drive
Cortland, New York 13045

We appreciate and thank you in advance for your expedience in forwarding this student's records.

Cortland Enlarged City School District

NYS Dental Health Certificate-

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

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

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

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

School: Name

Grade

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 ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

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.

Date of Exam: _____

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

CORTLAND ENLARGED CITY SCHOOL DISTRICT
HEALTH APPRAISAL FORM

Name:_____ Date of Birth:_____

School: _____ Gender: ☐ M ☐ F Grade: _____

IMMUNIZATIONS / HEALH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal
☐ Immunizations up to date

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

Significant Medical / Surgical History: ☐ See attached

_____

_____

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

Allergies: ☐ LIFE THREATENING ☐ Food:_____ ☐ Insect:_____ ☐ Other:_____
☐ Seasonal ☐ Medication: _____

PHYSICAL EXAM

Height:_____ Weight: _____ Blood Pressure: _____ U/A:_____

Body Mass Index: _____ _____ _____
Weight Status Category (BMI Percentile):
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision – without glasses/contact lenses Color: _____ Hyperopia: _____	R	L	
Vision – with glasses/contact lenses	R	L	
Vision – Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

Pertinent Heath Information:

Skin and Hair _____ Tanner stage: I. II.
Eyes and Eyelids _____ III. IV. V.
Ears and Eardrums _____
Nose and Throat _____
Teeth and Gums _____
Thyroid and Lymph Nodes_____
Chest and Heart _____
Abdomen _____
External Genitalia _____
Bones and Joints _____
Scoliosis _____
Feet _____
Other Observations: _____

Immunizations:

DPT _____ _____ _____ _____ _____
OPV _____ _____ _____ _____ _____
Measles _____ Mumps_____Rubella_____
MMR ____ _____ PROQUAD_____
TB Tine test _____ Results _____
HIB _____ _____ _____ _____
HEP B _____ _____ _____
HEP A _____ _____
Tdap _____ Td _____
Pediatrix _____ _____
Gardasil _____ _____ _____
Meningococcal _____ _____ _____
Varicella _____ _____

☐ **EXAM ENTIRELY NORMAL** Scoliosis: ☐ Negative ☐ Positive :_____

Specify any abnormality (use reverse of form if needed):_____

_____

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

☐ Free from contagious & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weigh train, crew, dance, track, run, walk, rope jump.

☐ Specify medical accommodations needed for school: _____ ☐ None
☐ Known or suspected disability: _____ ☐ Please monitor
☐ Restrictions: _____ ☐ Please monitor
☐ Protective equipment required: ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____
Parent's Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

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

Please print or type clearly

DISTRICT

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: ❑ Possible LEP ❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** _____ *specify*

2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ **English** ❑ **Other** _____ *specify*

3. What language(s) does the student understand? ❑ **English** ❑ **Other** _____ *specify*

4. What language(s) does the student speak? ❑ **English** ❑ **Other** _____ *specify*

5. What language(s) does the student read? ❑ **English** ❑ **Other** _____ *specify* ❑ **Does Not Read**

6. What language(s) does the student write? ❑ **English** ❑ **Other** _____ *specify* ❑ **Does Not Write**

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

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

_____ Month: Day: Year: _____

Signature of Parent/Guardian/Other *Date*

Cortland Enlarged City School District
1 Valley View Drive
Cortland, NY 13045 (607-758-4100)

Medicaid Consent

Parent Name and Mailing Address: Date: _____

_____

_____

_____

Dear Parent or Guardian of _____: DOB:
_____

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

I, _____as the parent/guardian of _____,

have received a written notification from the School District 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 may 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 to release the following records/information about my child to the State's Medicaid Agency for the purpose of 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
Written Order/Referral
Evaluation Reports
Session Notes
Medication Administration Report
Special Transportation Log
Other Personally Identifiable Information
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.

Parent/Guardian Signature: _____

Print Name: _____ Date