NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of School District: ______________________________________________________

Name of School: _____________________________________________________________

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

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

Date

If the student is NOT living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

Rev. 5/21/09
**STUDENT INFORMATION**

Name ___________________________ Preferred Name (if applicable) ___________________________

<table>
<thead>
<tr>
<th>FIRST</th>
<th>MIDDLE</th>
<th>LAST</th>
</tr>
</thead>
</table>

Mailing Address __________________________________________________________

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

Home Address __________________________________________________________

*(if different from mailing address)*

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

Home Phone: (____) ___________ Cell Phone: (____) __________________________

County of Residence:  □ Ontario  □ Wayne  □ Monroe

Birth Date: ___/___/____  Gender:  □ M  □ F

Who does the child live with?  □ Mother  □ Father  □ Step-Mother  □ Step-Father  □ Legal Guardian  □ Foster Parent

*Additional options available*

**SCHOOL RECORDS**

Name of School Last Attended __________________________ District __________________________

Street Address __________________________________________________________

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

Phone: (____) ___________ Guidance Office Fax Number: (____) __________________________

**STUDENT SERVICES**

Has your child ever been identified as having an educational disability?  □ Yes  □ No

If yes, please describe _______________________________________________________

Check which applies:  □ Student has a current Individualized Education Plan (IEP)

□ Student has a 504 Accommodation Plan

Please describe any Special Education Services that your child has received (i.e. speech, occupational therapy, physical therapy, resource, special class, remedial instruction): __________________________________________

Has your child received any other services (i.e. gifted/talented and/or English as a Second Language)?  □ Yes  □ No

If so, please describe _______________________________________________________

Are there any significant health problems?  □ Yes  □ No

Please specify:  □ Asthma  □ Allergies  □ Diabetes  □ Seizures  □ Other ___________________________
Student's Name ____________________________

PARENT/GUARDIAN INFORMATION
☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Legal Guardian ☐ Foster Parent

☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Legal Guardian ☐ Foster Parent

Name ____________________________

Name ____________________________

Address ____________________________

Address ____________________________

(if different from child's)
Home Phone ____________________________

Home Phone ____________________________

Cell Phone ____________________________

Cell Phone ____________________________

Work Phone ____________________________

Work Phone ____________________________

Employer ____________________________

Employer ____________________________

E-Mail Address ____________________________

E-Mail Address ____________________________

(if different from child's)

☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Legal Guardian ☐ Foster Parent

☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father ☐ Legal Guardian ☐ Foster Parent

Name ____________________________

Name ____________________________

Address ____________________________

Address ____________________________

(if different from child's)
Home Phone ____________________________

Home Phone ____________________________

Cell Phone ____________________________

Cell Phone ____________________________

Work Phone ____________________________

Work Phone ____________________________

Employer ____________________________

Employer ____________________________

E-Mail Address ____________________________

E-Mail Address ____________________________

Are there any custodial restrictions or an order of protection? Please explain: ____________________________________________________________

EMERGENCY CONTACTS (beyond parent/legal guardian)

Name ____________________________

Name ____________________________

Relationship to Child: ☐ Grandparent ☐ Neighbor ☐ Sitter ☐ Other

Relationship to Child: ☐ Grandparent ☐ Neighbor ☐ Sitter ☐ Other

Home Phone ____________________________

Home Phone ____________________________

Cell Phone ____________________________

Cell Phone ____________________________

Work Phone ____________________________

Work Phone ____________________________

SIGNATURE

Verification By Subscription And Notice Under Penal Law Section 210.45

It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York, for a person, in and by a written instrument, to knowingly make a false statement, or to make a statement, which such person does not believe to be true.

Affirmed under penalty of perjury this _______ day of ___________________ 20____

Signature ____________________________
AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION

Current School: ____________________________________________________________

Street Address: __________________________________________________________

City/State/Zip: __________________________________________________________

School/Guidance FAX: ____________________________________________________

Name of Student: _________________________________________________________

Student's New Address: ___________________________________________________

_______________________________________________________________________

Student's New Phone: ___________________ Current Grade: ________________

Permission is given to release the following school records:

____ Permanent record/transcript of grades  ____ Health Record
____ Attendance Records  ____ Standardized Test Results
____ Psychological Testing  ____ Speech/OT/PT Records
____ Other data as determined necessary and relevant to the appropriate educational
   programming for the above student.

Information should be forwarded to: Chris Overfield at address above

CSE Special Education Records please fax to CSE Office @ 585-742-7020 or mail to
Victor Central School District, 953 High St., Victor, NY 14564  Attn: Chris Overfield

Grade 9-12 School Records - Fax directly to Kristen Stone @ 585-742-7043.

________________________________________  _____________________________
Parent or Legal Guardian, or student if over 18 years  Date
of age.
This form is to be used anytime your child’s transportation changes during the school year. If any changes occur throughout the year (such as address, phone number, or sitter information) please notify the school and the Transportation Department 24 hours in advance. If we do not receive a form, your child will be picked up and dropped off at home.

Phone: 585-924-3252 Ext. 7120   Fax: 585-742-7026   Email: Tornstromk@victorschools.org

---

**THIS FORM PERTAINS TO ANY STUDENT IN GRADES K-6**

<table>
<thead>
<tr>
<th><strong>Today’s Date</strong></th>
<th><strong>Effective Date</strong></th>
<th><strong>Grade</strong></th>
</tr>
</thead>
</table>

Student Name ____________________________________________

Last

First

MI

Parent/Guardian Names ____________________________________________

Home Address ____________________________________________

Street

City/Town

Zip Code

Mailing Address (if different) ____________________________________________

Street

City/Town

Zip Code

---

**Contact 1**

Cell ____________________________________________

Email address ____________________________________________

Work phone ____________________________________________

Relationship to child ____________________________________________

---

**Contact 2**

Cell ____________________________________________

Email address ____________________________________________

Work phone ____________________________________________

Relationship to child ____________________________________________

---

**AM Bus Pickup Location**

Monday ____________________________________________

Tuesday ____________________________________________

Wednesday ____________________________________________

Thursday ____________________________________________

Friday ____________________________________________

PM Bus Drop Off Location

Monday ____________________________________________

Tuesday ____________________________________________

Wednesday ____________________________________________

Thursday ____________________________________________

Friday ____________________________________________

Name of childcare provider ____________________________________________

Address ____________________________________________

Street

City/Town

Zip Code

Home phone ____________________________________________

Cell phone ____________________________________________
To be filled out POST registration

1. Student Racial and Ethnic Identification Form
   2. Home Language Questionnaire
STUDENT RACIAL AND ETHNIC IDENTIFICATION FORM

(To be completed post-enrollment)

To the Parent/Guardian: The U.S. Department of Education and the New York State Department require the collection and recording of the racial and ethnic identity of students. The information will be used to:

- Report required data to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academics performance, attendance and completion of school.

This information 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.

Student’s Name:

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.]

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.

☐ YES, Hispanic
☐ NO, not Hispanic

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 South America (including Central America), and who maintains tribal affiliation or community recognition.

☐ 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.

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

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

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

(Signature of Parent/Guardian/Other) [Signature]

Relationship to Student (Please check one box below):

☐ Mother ☐ Father ☐ Legal Guardian ☐ Other (Specify): ________

(Date) [Date]

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.
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 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.

# Home Language Questionnaire (HLQ)

### Please write clearly when completing this section.

<table>
<thead>
<tr>
<th>STUDENT NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH:</th>
<th>GENDER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT/PERSISTER IN PARENTAL RELATION INFO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
</tr>
</tbody>
</table>

## 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  

2. What was the first language your child learned?  
   - English  
   - Other  

3. What is the Home Language of each parent/guardian?  
   - Mother  
   - Father  
   - Guardian(s)  

4. What language(s) does your child understand?  
   - English  
   - Other  

5. What language(s) does your child speak?  
   - English  
   - Other  
   - Does not speak  

6. What language(s) does your child read?  
   - English  
   - Other  
   - Does not read  

7. What language(s) does your child write?  
   - English  
   - Other  
   - Does not write  

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

<table>
<thead>
<tr>
<th>SCHOOL DISTRICT INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student ID Number in NYS Student Information System:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District Name (Number) &amp; School</th>
<th>Address</th>
</tr>
</thead>
</table>
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?
   _______________________________________________________________________

__________________________________________________________  ____________________________  ____________________________
Signature of Parent or of Person in Parental Relation  Month:  Day:  Year:  Date

Relationship to student:  □ Mother  □ Father  □ 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

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:

2
Victor Central School District  
Committee on Special Education  
Pupil Personnel Services  
953 High St.  
Victor, NY 14564 ((585) 924-3252 x 1451)

**Medicaid Consent**

Client Identification Number (CIN): ____________

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.

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

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: ____________