

CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Student Information:

Last Name, First Name, Middle	Nickname	Date of Birth (MM/DD/YEAR)	Gender <input type="radio"/> Male <input type="radio"/> Female
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Entering Grade	Ethnicity (choose one) <input type="radio"/> Hispanic/Latino <input type="radio"/> Not Hispanic/Latino	Place of Birth (City/State/Country)	Primary Language Spoken at Home
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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 of origin, regardless of race.

Yes, Hispanic
 No, Not Hispanic

Select one or more races from the following five racial groups. 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 people of North and South America (Including Central America), and who maintains tribal affiliation or community attachment.

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 or African American: 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.

Student's Residential Information

House #, Street Address		Apt. #	Student's Home Phone #
City	State	Zip Code	Student's Cell Phone #

Mailing Address if different:

Is this address a temporary living arrangement? YES NO

Resident of Clinton Central School District? YES NO, please list District:

Academic Information:

Has student attended Clinton Central School District in the past? YES NO

List grade levels repeated:

Last two schools attended	School 1	School 2
Name of school		
Address of school		
Phone number		
Grade levels completed		
Last date of attendance		
Name of counselor or contact person		

Please describe below any special educational needs of the student:

CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Parent/Guardian Information (Primary Household)					
Relationship to Student	Gender <input type="radio"/> Male <input type="radio"/> Female	Custody? <input type="radio"/> N/A <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> JOINT	Relationship to Student	Gender <input type="radio"/> Male <input type="radio"/> Female	Custody? <input type="radio"/> N/A <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> JOINT
Last Name, First Name			Last Name, First Name		
Home Phone #			Home Phone #		
Cell Phone #			Cell Phone #		
Employer			Employer		
Email Address			Email Address		
Residential Address SAME as Student? <input type="radio"/> YES <input type="radio"/> NO (if no, please complete area below)			Residential Address SAME as Student? <input type="radio"/> YES <input type="radio"/> NO (if no, please complete area below)		
House #/Street Name			House #/Street Name		
City/State/Zip Code			City/State/Zip Code		

Parent/Guardian Information (Secondary Household), if applicable					
Relationship to Student	Gender <input type="radio"/> Male <input type="radio"/> Female	Custody? <input type="radio"/> N/A <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> JOINT	Relationship to Student	Gender <input type="radio"/> Male <input type="radio"/> Female	Custody? <input type="radio"/> N/A <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> JOINT
Last Name, First Name			Last Name, First Name		
Home Phone #			Home Phone #		
Cell Phone #			Cell Phone #		
Employer			Employer		
Email Address			Email Address		
Residential Address SAME as Student? <input type="radio"/> YES <input type="radio"/> NO (if no, please complete area below)			Residential Address SAME as Student? <input type="radio"/> YES <input type="radio"/> NO (if no, please complete area below)		
House #/Street Name			House #/Street Name		
City/State/Zip Code			City/State/Zip Code		
Do not release to:			Relationship to Child:		

Emergency Contacts:						
Name	Gender	Relationship	Home Phone #	Work Phone #	Cell Phone #	Pick up from School?
						<input type="radio"/> YES <input type="radio"/> NO
						<input type="radio"/> YES <input type="radio"/> NO

Siblings who will enroll (or are currently enrolled) in Clinton Central Schools:				
Name	DOB	Grade	School	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I hereby declare under penalty of perjury that the information provided on this form is accurate and truthful to the best of my knowledge. I understand that the provision of false information may result in the exclusion of my child(ren) from attendance at the Clinton Central School District, the demand by the District for the payment of tuition, and/or the institution of any other appropriate legal action available to the District.

Parent/Guardian Signature _____ Date _____

CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Directory Information Non-Disclosure Request Form

The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires that Clinton Central School District, with certain expectations, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, Clinton Central School District may disclose appropriately designated "directory information" without written consent, unless you have advised the Clinton Central School District to the contrary in accordance with Clinton Central School District procedures.

***If you wish the District to require your written consent to disclose your child's directory information, please complete this form and return it to your child's building Principal, Dr. Matthew T. Lee. ***

Dear Dr. Lee,

Please do not release the name, address or telephone number of _____
to: *Student Name*

(Please check off choices below)

- Military recruiters
- Institutions of higher learning
- Clinton Parent Teacher Association
- Clinton School Foundation

Parent/Guardian Signature _____ Date _____

CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Student Residency Questionnaire

Student Information:

Last Name, First Name:

Gender: Male Female Other (please identify):

Grade Level:

Date of Birth: (MM/DD/YEAR)

Age:

Student Residency:

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? YES NO

2. Is this temporary living arrangement due to loss of housing or economic hardship? YES NO

If you answered YES to the above questions, please complete the remainder of this form. If you answered NO, you may stop here.

Where is the student presently living? (Please check one)

- In a motel
- In a shelter
- With more than one family member in a house or apartment
- Moving from place to place
- In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

Parent/Guardian Information:

Last Name, First Name:

Address:

Phone Number:

Does the child need transportation to and from school? (bus)

YES NO

If "Yes", Please notify the office at (315) 557-2235 with the date to start transportation.

Presenting a false record or falsifying records is all offense under Section 37.10, Penal Code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec 25.002(3)(d).

Signature of Parent/Legal Guardian

Date

Signature of School Official

Date

I certify that the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date

McKinney-Vento Liaison Signature

Anthony Sirianni, LCSW

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

**Clinton High School
75 Chenango Avenue
Clinton, NY 13323
315-557-2235
FAX: 315-557-2225**

Date: _____

To: Educational Records Access Officer

Prior School Name _____

Address _____

Fax Number _____

Name: _____ Date of Birth: _____

has enrolled in our school, grade level _____ .

Please send the following:

- Transcripts
- Final Grades, if possible
- Standardized Test Scores
- Current Student Schedule
- Health Records
- Psychological Records
- IEP or 504 for current/ previous school year. (Including phase I for current year)
- Results of any other educational testing on individual student

Please send records to: Counseling Department
Clinton High School
75 Chenango Avenue
Clinton, NY 13323

Counselor Signature
Jacqueline Snizek (Last names A-K, grades 9-12)
Kelly Zegarelli (Last names L-Z, grades 9-12)

I give permission for my student's educational records and pertinent information to be released to Clinton High School.

Parent/ Guardian Signature

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

Clinton Central School District SchoolTool Parent Portal Access Request Form

The Clinton Central School District is pleased to offer "Parent Portal" through our student management system. SchoolTool provides access to parents and guardians for student information at the high school level. Parents and guardians will be able to access their child(s) academic, attendance, class schedule, and discipline information at their convenience. The attendance and discipline information will automatically be updated in the Parent Portal, but report cards and progress report grades will be uploaded at the appropriate times.

Please provide the following information which will assist us in granting you access to the Parent Portal:

Parent/Guardian name (please print): _____

Parents, guardians, or person in parental relation of the student(s) please fill out the information in the table below:

First Name	Last Name	Address where Student Resides	Date of Birth	Grade

The district will provide the chosen parent/guardian with a login and password that will allow access information about their student(s) school performance. This information is stored in a database called SchoolTool which is maintained by the District with support from the Mohawk Regional Information Center of the Madison-Oneida BOCES.

In return for the District providing me with a login/password, I agree to the following Terms of Network Access:

Please initial each item to acknowledge it, and sign at the end

_____ I will maintain a valid email address that the District may use to send me pertinent information concerning my Parent Portal Account.

My email address: _____

_____ I will only attempt to view information about the student(s) listed on the second page of this form. I will not attempt to "hack", manipulate, or otherwise try to evade the security measures to access information regarding any other person.

_____ I will not intentionally transfer to the schooltool™ system any virus, Trojan horse, or other malicious computer code.

_____ If granted the ability (at a future time) to enter data into my child's record, I will only enter accurate information.

Continue to the next page

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

Please initial each item to acknowledge it, and sign at the end

- _____ I understand that the District's use of the schooltool™ software is supported by technical assistance from the Mohawk Regional Information Center (MORIC), Mindex™ Technologies Inc., and possibly other consultants and employees of these entities. They are instructed to keep any confidential personally-identifiable information, including educational records, they may see in the performance of their duties. I consent to the disclosure of information about me or the student(s) listed above under these circumstances.
- _____ I understand that all information stored in the schooltool™ database remains property of the District, and may be accessed, examined, or modified by the District or its vendors at any time.
- _____ I understand that the schooltool™ database may record and retain information about when and how I use schooltool™ through the Parent Portal and that this information is the property of the District and subject to review by the District.
- _____ I agree that I will not disclose my username and password to any other person, not even other people in my family or household. I accept responsibility for all actions that are performed by anyone gaining access to the schooltool™ database using the username and password assigned to me.
- _____ I understand that the District retains the discretion to block my access to schooltool™ whenever it has reasonable suspicion to believe that I have violated one of the aforementioned Terms of accessing schooltool™ and other network resources.

Parent/Guardian Name (please print)

Date: _____

Parent/Guardian Signature

Date: _____

Please have your child return this completed form to the main office.

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

New Student Health History

STUDENT INFORMATION:			
Last Name, First Name, Middle		Date of Birth (MM/DD/YEAR)	Place of Birth (City/State/Country)
Gender <input type="radio"/> Male <input type="radio"/> Female	Mother's Name	Father's Name	
House #, Street Address			Apt. #
City	State	Zip Code	Home Phone #
Number and ages of siblings:			

STUDENT HEALTH INFORMATION:	
1. Was your child born prematurely? <input type="radio"/> YES <input type="radio"/> NO	
2. Did he/she have any growth or development problems as an infant or young child? <input type="radio"/> YES <input type="radio"/> NO	
3. Does your child have any of these health problems? If so, please check and explain.	
<input type="checkbox"/> Ear problems _____ <input type="checkbox"/> Eye problems _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Headaches _____ <input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Heart Condition _____ <input type="checkbox"/> Nosebleeds _____ <input type="checkbox"/> Seizure Disorder _____ <input type="checkbox"/> Other _____
4. What medications have been prescribed for these episodes? Are the medications taken on a daily or as needed basis?	
<input type="checkbox"/> Medications/Drugs: _____ <input type="checkbox"/> Foods/Plants: _____ <input type="checkbox"/> Bee/Insect Bites: _____ <input type="checkbox"/> Animals/Other: _____ <input type="checkbox"/> Treatment recommended by a physician for allergic response: _____	
Is your child receiving allergy shots? <input type="radio"/> YES <input type="radio"/> NO	Has asthma been diagnosed by a physician? <input type="radio"/> YES <input type="radio"/> NO
What treatment or medications have been prescribed for these episodes are/or to be taken on a regular basis?	

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

5. Has your child had any of the following illnesses? If yes, please give dates and explanation.

- | | |
|---|--|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Scarlet Fever _____ |
| <input type="checkbox"/> German Measles _____ | <input type="checkbox"/> Strep throat/multiple infections _____ |
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Mononucleosis _____ | <input type="checkbox"/> Tuberculosis or a family member
(indicate relationship to child) _____ |
| <input type="checkbox"/> Mumps _____ | _____ |
| <input type="checkbox"/> Pneumonia _____ | _____ |

6. Please list specific illnesses, injuries or surgeries:

_____ @ age _____ hospitalized for _____ days
_____ @ age _____ hospitalized for _____ days
_____ @ age _____ hospitalized for _____ days

7. Does your child have any disabilities or chronic illness? YES NO

8. Does your child take any medications on a regular basis? YES NO

IF YOUR CHILD REQUIRES MEDICATION DURING THE SCHOOL DAY, PLEASE CONTACT THE SCHOOL NURSE REGARDING THE SCHOOL MEDICATION POLICY

9. Has your child ever been diagnosed or treated for an emotional disorder? YES NO

10. Does your child wear glasses or contact lenses? YES NO

For what situation are glasses worn? _____
Are they safety plastic or polycarbonate lenses? _____
Date of most recent vision exam: _____

11. Does your child have dental problems, or is he/she receiving orthodontic treatment? YES NO

12. What is the date of his/her most recent exam?

13. What school did your child last attend?

14. Was the most recently completed school year a healthy one for your child? YES NO

15. Approximately how many school days did he/she miss because of illness during the last school year?

16. Have you already provided the school with a record of your child's immunizations? YES NO

(A signed record from a physician or clinic, or a copy of a school immunization record, must be presented before school attendance begins. If this information is not received, New York State Public Health Law requires that your child be excluded from school.)

Parent/Guardian Signature: _____

Date: _____

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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:	Gender: <input type="radio"/> Male <input type="radio"/> Female	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY:

Allergies: <input type="radio"/> NO <input type="radio"/> YES, Indicate Type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached	
	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental		
Asthma : <input type="radio"/> NO <input type="radio"/> YES, Indicate Type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached	
	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other:		
Seizures: <input type="radio"/> NO <input type="radio"/> YES, Indicate Type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached	
	<input type="checkbox"/> Other:	<input type="checkbox"/> Date of last seizure:	
Diabetes: <input type="radio"/> NO <input type="radio"/> YES, Indicate Type	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached	
	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results:	<input type="checkbox"/> Date Drawn:	
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): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and >	
Hyperlipidemia:	<input type="radio"/> NO <input type="radio"/> YES	Hypertension:	<input type="radio"/> NO <input type="radio"/> YES

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion - Last Occurrence:
Lead Level Required Grades Pre-K & K			Date	<input type="checkbox"/> Mental Health:
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ µg/dL				<input type="checkbox"/> Other:
<input type="checkbox"/> System Review and Exam Entirely Normal				
Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph Nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code
			_____	_____
			_____	_____
			_____	_____
<input type="checkbox"/> Additional Information Attached				

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

Name:	DOB:
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SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision — Near Vision	20/	20/		
Vision — Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 and girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling.

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level OR grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

<input type="checkbox"/> Brace*Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:

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

Explain:

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home:

IMMUNIZATIONS

Record Attached Reported in NYSIIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please return this form to your child's school when entirely completed.

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. TO BE COMPLETED BY A PARENT OR GUARDIAN:

I request that my child _____ grade _____ receive medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the original container from the pharmacy. I understand that the school nurse will administer the medication or an adult will supervise my child taking his/her own medication.

Parent/Guardian Signature:

Date: _____

B. TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER:

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

Name of student:

Date of birth:

Diagnosis:

Name of medication:

Prescribed dosage, frequency, and route of administration:

Time to be taken during school hours:

Duration of medication order:

Possible side effects and adverse reactions (if any):

Other recommendations:

Name of licensed prescriber and title (please print):

Prescriber's Signature:

Date: _____

Address:

Phone: _____

*Under certain conditions it may be necessary for a student to carry and self administer his or her own medication. The decision to allow a student to do this will be made on an individual basis, according to the severity of the health condition, with parental request, by a physician's order, and an assessment by the school nurse of the student's ability to carry and administer his/her medication properly. **The self medication release form must be completed.***



Lissette Colon-Collins, Assistant 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 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.

Please write clearly when completing this section.		
STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i>specify</i>	<input type="checkbox"/> Father _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
		<input type="checkbox"/> 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? _____

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.

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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM



NEW STUDENT ATHLETIC PARTICIPATION FORM

Student: _____ Date: _____

Entering Grade: _____ Male Female Date of Birth: _____ Age _____

Date of last Health Examination (Physical): _____ Attached Documentation

New Address: _____

Parents' Name: _____ Telephone: _____

With Whom Are You Living In This District? _____

***** PREVIOUS SCHOOL INFORMATION *****

Previous School: _____

Sports Played in Previous School

Level & Number of Years Played

Fall	Sport _____	_____ Modified _____	JV _____	Varsity _____
Winter	Sport _____	_____ Modified _____	JV _____	Varsity _____
Spring	Sport _____	_____ Modified _____	JV _____	Varsity _____

Previous Address: _____

With Whom Did You Live? _____

Reason For Leaving Previous School: _____

Were you subject to the APP Process as a 7th or 8th grader? Yes No

***** ACADEMIC INFORMATION *****

Year Entered 9th Grade: _____ Verification: _____

Counselor's Initials

Have you repeated a grade in JR High or High School? Yes No

If Yes, which grade: _____

Date of the student's registration accepted: _____

Guidance Department should forward this form to the Director of Athletics when student has been accepted for registration. Please list any other high school attended on back.