Oriskany Central School District Student Registration Packet

OFFICE USE ONLY	Date Received by Central Registration:
Student ID#: _____	Date Entered: _____
Proof of Age: □Birth Certificate □Passport □Baptismal Certificate □DS2999 □Other_____	
Anticipated grade level upon entry: _____ Is this enrollment a re-entry to the district? □YES □NO	
Last grade attended in this District: _____ Last school attended in this District: □N.A. Walbran ES □ Oriskany Jr/Sr High School	
☐ SPECIAL EDUCATION: □YES □NO	ALL DAY BOCES: □YES □NO

STUDENT INFORMATION

Last: (Legal name only)	First:	Middle:	Suffix (Jr., II, III)	Gender: ☐ Male ☐ Female
Other name(s) used previously (AKA):	Nickname:	Date of birth:	Age:	

PARENT/GUARDIAN INFORMATION

Indicate child's primary residence if not with both parents. Documentation of legal custody must be provided.

Father/Guardian ☐ Primary Residence		Mother/Guardian ☐ Primary Residence		Maiden Name:
Name:		Name:		
Address:		Address:		
Mailing Address (if different):		Mailing Address (if different):		
Phone 1: ☐ home ☐ cell	Phone 2: ☐ work ☐ cell	Phone 1: ☐ home ☐ cell	Phone 2: ☐ work ☐ cell	
Email:		Email:		
Place of employment:		Place of employment:		
Occupation (optional)		Occupation (optional)		

Is one or both of the student's parents currently on full-time Active Duty in the Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) or was at one point during this school year? If Yes, what date did the parent(s) begin full-time active duty in the Armed Forces?_____ Was it Father, Mother, Stepfather, Stepmother?—please circle. If the parent(s) are no longer full-time active duty in the Armed Forces and was earlier in the school year, what was the exit date?

FOSTER CARE PLACEMENT – Complete this section only if child is in foster care.

Foster Parent name:	Relationship to child:	Phone 1: ☐ work ☐ cell	Phone: ☐ work ☐ cell
Address:			
Employer:	Child's School District of Origin:		
Agency placing child:		Date Child was placed:	
Name of agency caseworker assigned to the child:		Phone:	
School Last Attended:	School Address:		

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Has your child ever been retained? ☐ No ☐ Yes	Grade:	Year:
Has your child ever been in a special program? ☐ No ☐ Yes	In a special education program? ☐ No ☐ Yes	
If YES, for what program?	Date in program?	
Specific Learning Disability ☐ No ☐ Yes Dates in program:	Intellectual Disability ☐ No ☐ Yes Dates in program:	Emotionally Disabled ☐ No ☐ Yes Dates in program:
Visually Impaired ☐ No ☐ Yes Dates in program:	Physically Disabled ☐ No ☐ Yes Dates in program:	Occupational/Physical Therapy ☐ No ☐ Yes Dates in program:
Speech, Hearing, and Language Impaired ☐ No ☐ Yes Dates in program:	Remedial Reading ☐ No ☐ Yes Dates in program:	Remedial Math ☐ No ☐ Yes Dates in program:
If your child was in a special program, indicate where school records may be obtained:		
School Name:		Phone:
Address:		
Information and documentation provided:		
☐ Current IEP ☐ Current Psychological ☐ Current Social History ☐ Current medical Records		
Current physician's prescription for any of the following therapies being received in school:		
☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy		

Special Education Services

The objectives of the Oriskany Central School Special Education Programs are reflective of the intent of IDEA, and are aligned with the regulations of the Commissioner of Education as set forth in Article 89 of the New York State Education Law. The purpose of special education is to provide a free and appropriate education in the least restrictive environment for students under the age of twenty-one identified as having educational difficulties. Special Education is intended to address individual academic, social, physical, and management needs as identified by a student's Individualized Education Plan (IEP). Specialized instructional strategies and materials are used to individualize instruction so that students with disabilities can benefit from the district's programs.

Oriskany Central School is committed to providing students with an inclusive education experience whenever possible. Students not served in district have intensive needs that cannot be met within district programs and services.

Our Contact Information:

Ms. Denise Mazza
CPSE/CSE Chairperson/504 Coordinator
Phone: 315.768.2048
Fax: 315.768.2081
Email: dmazza@oriskanycsd.org

Ms. Sarah Walker
Oneida-Herkimer-Madison BOCES
CPSE Coordinator- Preschool
Phone: 315-223-4727
Fax: 315-557-2680
Email: swalker@oneida-boces.org

Mrs. Kathie Higgins
CSE/CPSE/504 Secretary
Phone: 315.768.2048
Fax: 315.768.2081
Email: khiggins@oriskanycsd.org

Oriskany Central School's
Link for Parent's Guide to Special Education
http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

Oriskany Central School District Student Registration Packet

SIBLINGS

Name	Gender: M/F	Date of Birth	Grade	Full/Half/Step	Residence
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other
					☐ Home ☐ Other

EMERGENCY CONTACTS

Person or relative who we can contact if you are not reachable by phone. Those listed will have pick-up rights.

Name	Address	Phone	Relationship to Child

If none of the above named can be reached, please call an available licensed physician and take my child to the nearest Emergency Aid Station by ambulance if necessary. I realize that the school district cannot assume responsibility for payment of medical fees or expenses incurred beyond the limit of school insurance.

Hospital Choice_____ Physician Name/Phone_____

*** I hereby approve the above list and further agree to provide written notification of any changes in the above listing.**

PARENT/GUARDIAN SIGNATURE_____ DATE_____

Oriskany Central School District Student Registration Packet

MEDICAL INFORMATION (TO BE COMPLETED BY PARENT/GUARDIAN)

The following information is a necessity to ensure that health records pertaining to your child are current and accurate.

(Legal name only) Last name	First	Middle	Suffix (Jr., II, III)	Gender ☐ Male ☐ Female
Other name(s) used previously (AKA)	Nickname	Date of birth	Age	Grade Level
Student Address:				Phone: ☐ Home ☐ Cell
Father's Name:	Mother's Name:			Mother's Maiden Name:
Guardian/Step-parent's Name:	Student resides with *(Father, Mother, Guardian, Other-Indicate relationship)*			
Physician Name and Address:				Phone:
Dentist Name and Address:				Phone:
Emergency Contact Name (1):	Phone:			Relationship:
Emergency Contact Name (2):	Phone:			Relationship:

NOTE: If none of the above named can be reached, please call an available licensed physician and take my child to the nearest Emergency Aid Station by ambulance if necessary. I realize that the school district cannot assume responsibility for payment of medical fees or expenses incurred beyond limit of school insurance. Parent/Guardian Signature_____

Physical Examinations: The New York State Education Law requires a physical examination before entrance to school and routinely at grades Pre-K, K, 2, 4, 7, 10 and athletes.

Student to be examined: ☐ In school ☐ By family physician	Parent/Guardian Signature:	Date:

Immunizations: *Please attach a copy of your child's most recent immunization records from their physician.*

	Health History			
	Please complete the following as accurately as possible.			
Allergies to food, drugs, bees, animals, or environmental	☐ No	☐ Yes	Type of allergy :	Medication taken:
Hay fever, asthma wheezing	☐ No	☐ Yes	If yes, indicate dates and explain:	
Eczema or frequent skin rashes	☐ No	☐ Yes	If yes, indicate dates and explain:	
Convulsions or seizures	☐ No	☐ Yes	If yes, indicate dates and explain:	
Heart trouble or murmurs	☐ No	☐ Yes	If yes, indicate dates and explain:	
Diabetes	☐ No	☐ Yes	If yes, indicate dates and explain:	
Tuberculosis	☐ No	☐ Yes	If yes, indicate dates and explain:	
Kidney Disease	☐ No	☐ Yes	If yes, indicate dates and explain:	
Pneumonia	☐ No	☐ Yes	If yes, indicate dates and explain:	
Frequent (more than 3 times a year) colds, sore throat, or ear aches	☐ No	☐ Yes	If yes, indicate dates and explain:	
Rheumatic fever / scarlet fever	☐ No	☐ Yes	If yes, indicate dates and explain:	
Mononucleosis	☐ No	☐ Yes	If yes, indicate dates and explain:	
Chicken Pox	☐ No	☐ Yes	If yes, indicate dates and explain:	

Health History…continued

Measles/Mumps/Rubella (3 day measles)	☐ No	☐ Yes	If yes, indicate dates and explain
Meningitis	☐ No	☐ Yes	If yes, indicate dates and explain
Strep Infections	☐ No	☐ Yes	If yes, indicate dates and explain
Anemia	☐ No	☐ Yes	If yes, indicate dates and explain
Concussion/Head Injury	☐ No	☐ Yes	If yes, indicate dates and explain
Orthopedic Problems (brace)	☐ No	☐ Yes	If yes, indicate dates and explain
Nosebleeds	☐ No	☐ Yes	If yes, indicate dates and explain:
Headaches	☐ No	☐ Yes	If yes, indicate dates and explain:
Arthritis	☐ No	☐ Yes	If yes, indicate dates and explain:
Polio	☐ No	☐ Yes	If yes, indicate dates and explain:
Scarlet Fever	☐ No	☐ Yes	If yes, indicate dates and explain:
Pertussis (whooping cough)	☐ No	☐ Yes	If yes, indicate dates and explain:
Diptheria	☐ No	☐ Yes	If yes, indicate dates and explain:
Fainting Spells	☐ No	☐ Yes	If yes, indicate dates and explain:
Medications/Herbal Remedies	☐ No	☐ Yes	If yes, indicate dates and explain:
Speech Problems	☐ No	☐ Yes	If yes, indicate dates and explain:
Bowel or urinary problems	☐ No	☐ Yes	If yes, indicate dates and explain:
Nutrition or weight problems	☐ No	☐ Yes	If yes, indicate dates and explain:
Behavior, developmental, or maturity problems	☐ No	☐ Yes	If yes, indicate dates and explain:
Social adjustment problems (family, friends, school)	☐ No	☐ Yes	If yes, indicate dates and explain:
Severe accidents or injuries	☐ No	☐ Yes	If yes, indicate dates and explain:
Hospitalizations	☐ No	☐ Yes	If yes, indicate dates and explain:
Surgery	☐ No	☐ Yes	If yes, indicate dates and explain:
Known vision problems	☐ No	☐ Yes	If yes, indicate dates and explain:
Known hearing problems	☐ No	☐ Yes	If yes, indicate dates and explain:
Pain in legs, arms, back or joints	☐ No	☐ Yes	If yes, indicate dates and explain:
Limp or unusual walk	☐ No	☐ Yes	If yes, indicate dates and explain:
Balance issues or unexplained sudden movements	☐ No	☐ Yes	If yes, indicate dates and explain:
Other physical problems not mentioned	☐ No	☐ Yes	If yes, indicate dates and explain:
Did child attend preschool?	☐ No	☐ Yes	If yes, what school?

Health History…continued

Medications: Is your child taking any medication? (If child needs medication administered in school, a medication request form must be completed and signed by a physician before medication will be given at school.)			
☐ No ☐ Yes	Name of medication and dosage:		Reason for medication:
Prenatal history:	Child's birth weight:	Duration of pregnancy:	Prenatal difficulties:
Did the child have any difficulties at birth? ☐ No ☐ Yes	If yes, explain:		
Physical Activity: Does your child have any physical difficulty that would prevent them from participating in the normal physical education class or other activities? (If your child is unable to participate in physical education class, then a physician's certificate is required.)			
☐ No ☐ Yes	If yes, explain:		

ORISKANY CENTRAL SCHOOL DISTRICT NURSES

N.A. Walbran Elementary School
Mrs. Julianne Swienton, RN
Phone: 315-768-2148
Email: jswienton@oriskanycsd.org

Oriskany Jr/Sr High School
Mrs. Maryruth Stopera, RN
Phone: 315-768-2061
Email: mstopera@oriskanycsd.org

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 oral health assessment? ☐ 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist'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):_____

II. 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. (3/2018)

ADVANCE NOTICE OF MEDICAL EXAMINATION OF PUPILS

School Health Services

Name of Pupil_____ Date:_____

Grade: _____

A medical examination of school children is required by law. You may have this examination made by your family physician, any private physician or by the school physician as you desire. You are encouraged to have this examination made by your family physician. He is familiar with your child and can undertake laboratory tests and corrections which the school physician is not authorized to perform.

If you wish to have your child is examined by your own doctor, please advise upon this form, which must be in the hands of the School Nurse within one week. Upon receipt of this notice by the nurse, she will send you an examination blank which you will take with your child to your doctor who will fill out after the medical examination. Following this you will kindly return this form promptly to the School Nurse.

Please remember that unless the examination by your physician is made and the health card properly filled out by him/her and returned to the School Nurse by _____, the school
(Date)
physician will examine your child.

For your information, the examination consists of weighing and measuring, testing hearing and vision, observance of general nutrition, examination of nose and throat, teeth, skin, posture, and heart and lungs. The School Nurse is present in every case and assists in the examination. You will promptly be advised of any defects discovered by this examination, in order to insure prompt correction.

Please sign below according to your choice, and have this blank returned promptly to the School Nurse.

I wish to have the required examination made by my own physician

_____

Signature of Parent/Guardian Date

I wish the examination made by the school physician.

_____

Signature of Parent/Guardian Date

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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ 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):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ 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 the 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

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ 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: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424

Are you the legal guardian of the child being enrolled?

☐ **YES** ☐ **NO** ☐ **FOSTER CARE**

Legal Guardianship

If you wish to enroll a minor student, you must show proof of legal guardianship.

- ✓ Legal guardianship of such students shall be documented by a copy of:

  a. legal documents showing that temporary or full legal guardianship has been applied for or awarded by a court of competent jurisdiction; or

  b. legal documentation showing that custody has been legally awarded to an extended family member; or

  c. documentation of placement under any court of competent jurisdiction or by any state agency having jurisdiction; or

  d. DDS 2999 if in foster care

This authority must be granted or legal proceedings initiated prior to enrollment of the student in the Oriskany Central School District. In addition, the requirements of proof of residency shall be met.

- ✓ Proof of the continuation of this status shall be required for each year the student is enrolled in Oriskany Central Schools.
- ✓ Such student shall be assigned to a school based upon the guardian's residence.
- ✓ Homeless children without a parent or legal guardian, or unaccompanied youth shall be granted an exemption from the requirements of this section on legal guardianship. If a child or unaccompanied youth attempts to register without a parent or legal guardian, school personnel shall attempt to determine whether the child is homeless in accordance with New York law.

I, the undersigned attest by my signature, that I am the legal guardian for the below named child.

_____ _____

Print Child's Name Date

_____ _____

Print Legal Guardian/Foster Parent's Name Legal Guardian/Foster Parent's Signature

Falsifying Records is punishable by law.

Presenting false information or records is a criminal offense under Penal Code 37.10. Enrolling the child under false documents makes the person liable for tuition or the cost.

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424

PROOF OF AGE AND IDENTITY

(Not applicable if Birth Certificate is provided)

Entrance into public school requires proof of both age and identity. The following documents are acceptable as proof of age and identity: (1) certified birth certificate, (2) certified record of baptism, (3) passport with date of birth, or (4) other documentation or legal record in existence for two years or more that is satisfactory to certification officer. I acknowledge that I am aware of the current requirement to provide proof of age and identity in order to enroll in the Oriskany Central School District.

Additionally, I am aware that I have 5 days to produce said document or my child will not be allowed to attend school.

_____
Signature of Parent/Legal Guardian/Foster Parent

_____
Today's Date

Further, I acknowledge that I have received a copy of this document and will provide the missing document within the five day timeframe.

_____
Signature of Parent/Legal Guardian/Foster Parent

_____
Today's Date

For Office Use Only

As Central Registrar my signature below indicates that I have provided a copy of this document to the person(s) registering a student in the Oriskany Central School District.

_____
Signature of District Registrar

_____
Today's Date

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424
315-768-2060

STUDENT REGISTRATION/CHANGE FORM FOR TRANSPORTATION

☐ **New Enrollment** ☐ **Address Change** for ☐ Pick up ☐ Drop off

Student's Name: _____
Last Name First Name Middle

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female

PICK UP LOCATION: _____
Address **Name** **Phone #**

_____
Home Description

DROP OFF LOCATION: _____
Address **Name** **Phone #**

_____
Home Description

Home Phone #: _____ Mom's Cell #: _____ Dad's Cell #: _____

Parent's/Guardian's Name Printed: _____

911 Home Address: _____ City _____ State _____ Zip _____

Mailing Address: _____ City _____ State _____ Zip _____

Emergency Contact: _____
Name Address Phone Home#/Cell#

Emergency Contact: _____
Name Address Phone Home#/Cell#

List any physical/emergency medical information bus drivers need to know about your child: _____
_____

Home Building: ☐ N.A. Walbran ☐ Oriskany Jr/Sr High School Current Grade: _____

Is Student Special Education? ☐ YES ☐ NO

DO NOT WRITE IN THIS SPACE- TRANSPORATION USE ONLY

STUDENT ASSIGNED TO ROUTE: _____ DATE TO START: _____

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of LEA: **ORISKANY CENTRAL 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 SCHOOL/LEAS: If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424

Standard Residency Agreement

INSTRUCTIONS: Insert names and pertinent information where indicated. Although phrased in the plural, this affidavit is also intended for use by single parents so as to avoid multiplicity of forms. One form should be prepared for **each child**.

State of New York, County of Oneida:

_____ and _____

If both parents are living together, list mother and father on the above lines; OR If one parent lives with a significate other, list both names on the above lines;

_____ being duly sworn, deposes and state:

OR If you are a single parent living alone, use the above line to list your name.

We(I) are(am) the parent(s) of _____ who is an applicant for admission and is a resident of the Oriskany Central School District. We(I) presently reside with our(my) child at the below physical address which is also within the boundaries of the Oriskany Central School District.

_____

Please list your physical address on the above line (not your mailing address).

In order to induce the Oriskany Central School to accept our(my) child, we(I) duly CERTIFY that the foregoing physical address is our(my) legal domicile or place where we(I) intend to permanently reside with our(my) child both at the date of this affidavit and for the duration of his/her enrollment as a student in the Oriskany Central School District.

We(I) agree, upon request of District Officials, to furnish such Officials with written verification that the listed address is our(my) permanent place of residence. Such written evidence may include vehicle registration records or any other piece of evidence tending to verify that the foregoing address is our(my) domicile or permanent place of residence.

We(I) agree that in the event our(my) permanent residence changes during the period of our(my) child's enrollment in the Oriskany Central School District, we(I) shall immediately advise District Officials as to our(my) new place of residence.

_____
Parent/Legal Guardian/Foster Parent Signature

_____
Parent/Legal Guardian/Foster Parent Signature

For Office Use Only

Witnessed before me this ____ day of _____, _____.

_____
District Registrar

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer, NY 13350
315-867-2079

Eligibility Screen for Migrant Education Services

*****Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed.*****

Has your family moved to a different school district in the last 3 years? Yes_ _ No_ _

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) Yes_ _ No_ _

If yes, what farm did you work on? _____ Where?_____ When? _____

If you can answer **YES** to **BOTH** of the above questions, your family **MAY** qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name _____ DOB _____ Grade _____

Child's name _____ DOB _____ Grade _____
Child's name _____ DOB _____ Grade _____
Child's name _____ DOB _____ Grade _____

Parents/Guardians

Mother's Name _____ Father's Name _____

Home Address _____ Home Phone# _____
(Street Address)
_____ Work or Message # _____
(City, Town, or Village, Zip)

School District _____ School Building _____

School Contact Person _____ Contact Number _____

Other useful information (directions, farm names, best time to contact, etc.)

To submit this referral please fax to the Herkimer BOCES at 315-867-2087 or mail to the address above. For more information, please call the Migrant Program at 315-867-2079.

Thank you for your assistance.

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer, NY 13350
315-867-2079

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*****Servicios de Programa de Educación Migrante son gratuitos y pueden incluir tutoria, ayuda con necesidades de salid, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario.*****

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí☐ NO☐

¿En los últimos 3 años ha trabajodo un padre o guardián en granja como: lechería, plantando cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Sí☐ NO☐

Si UD dijo que si, ¿en que granja? _____ ¿Donde?_____ ¿Cuándo?_____

Si Usted contestó que Sí a AMBOS preguntas de arriba, su familia PUEDA calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la infomación de abajo.

Nobre del niño(a) _____ Fecha de Nacimiento_____ Grado_____

Nobre del niño(a) _____ Fecha de Nacimiento_____ Grado_____

Nobre del niño(a) _____ Fecha de Nacimiento_____ Grado_____

Nobre del niño(a) _____ Fecha de Nacimiento_____ Grado_____

Padres/Guardianes

Nobre de la Mamá _____ Nombre del Papá _____

Dirección de la Casa _____ Numero de teléfono en casa _____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mesaje _____
(Ciudad o Pueblo, Código Postal)

Distrito escolar _____ edificio escolar _____

Persona para contactar _____ numero para contactar _____

Otra infomacion importante (direcciones, nombres de granjas, major hora de llamar, etc.)
_____
_____
_____

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a 315-867-2087 o mandar por correo al dirección de arriba.
Para más infomación, favor de llamar al Programa Migrante a 315-867-2079.
Gracias.

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424

PARENTAL PERMISSION FOR USE OF STUDENT PHOTOS/STUDENT WORK

Occasionally Oriskany classroom situations, events and activities are photographed or video taped with the int ent of utilizing select photos or film footage for information or promotional materials. This would include new spaper articles, pamphlets, displays or presentations, and other social media outlets.

Please check whether or not your child's photo or image may be used for the current school year for the abov e mentioned purposes.

Please check the appropriate box(es):

I ☐ **DO** OR ☐ **DO NOT** give permission to the following school buildings (as checked) to use my child(ren)'s image in the newspaper and/or on the school district website and/or school district related social media sites.

☐ **Oriskany Jr/Sr High School** ☐ **N.A. Walbran Elementary School**

Student Name: _____ Current Grade: _____

Signature of Parent/Guardian/Foster Parent: _____

Date: _____

Oriskany Central School District Acceptable Use Policy

Computers and networks can provide access to resources on and off school grounds, as well as the ability to communicate with other users worldwide. Such open access is a privilege, and requires that individual users act responsibly. Users must respect the rights of other users, school district, state, and federal laws, regulations, and contractual obligations. (The Oriskany Central School District Computer Use Policy is outlined in the Student Handbook.)

Students and other users may have the rights of access to their own files or e-mail created on the system. There is no expectation of privacy. Files and e-mails may be subject to monitoring without notice. In addition, the system operator may access files as required to protect the integrity of the computer system/network. Internet blocking software will be used to align on-line searching with the curriculum. All work and e-mail created on the system is the property of the Oriskany Central School District.

Misuse of computing, networking, or information resources may result in the loss of computer privileges and/or district, state, and/or federal penalties. Examples of misuse include, but are not limited to, the activities in the following list:

- Using a computer account that you are not authorized to use. Obtaining an ID and/or password for a computer account without the consent of the account user and system operator prior to use.
- Changing the assigned password or using encryption programs are not permitted without the consent of the system operator.
- Using the Oriskany Central School District's computer network to gain unauthorized access to any computer systems.
- Knowingly running or installing on any computer system or network, or giving to another user, a program intended to damage or place excessive load on a computer system or network. This includes, but is not limited to, programs known as computer viruses, Trojan horses, and worms.
- Attempting to circumvent data protection schemes or uncover security loopholes.
- Violating terms of application software licensing agreements or copyright laws.
- Deliberately wasting computer resources.
- Using electronic mail to harass others.
- Masking the identity of an account or machine.
- Posting materials on electronic bulletin boards and/or newsgroups that violate existing laws or the districts' code of conduct.
- Attempting to monitor or tamper with another user's electronic communications, or reading, copying, changing, or deleting another user's files or software without the explicit agreement of the owner in advance.
- Using the computer system/network to plagiarize or violate copyright laws.
- Altering the computer system/network for personal use or profit.

Proper use of technology and behavior that demonstrates responsibility is an expectation of all users. Access to use of the technology will not be granted without the signed agreement of both the student and the parent. Continued access to and use of the technology will be based on appropriate use as outlined in the policy signed by the student and the parent. Users will also be reminded of this acceptable use policy each time they log-in on the system.

The above Computer Acceptable Use Policy for the Oriskany Central School System has been read and explained to me by the district's computer system personnel. I understand and agree to comply with this policy.

Student Name: _____ Grade_____
Student Signature: _____Date: _____

I have read the above policy. I know that I may contact the district's computer system personnel by phone or in writing with any concerns. I understand and agree to this policy as it pertains to my son/daughter/or person under my charge.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date:_____

Oriskany Central School District
1313 Utica Street
Oriskany, NY 13424

To the Parent/Guardian: The *ORISKANY CENTRAL SCHOOL DISTRICT* has adopted a policy which requires the collection and recording of the ethnic identity of students in the *ORISKANY 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.**
- ✓ **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 next page. Put a check (✓) in the box for the category or categories which best describes your child. The *ORISKANY 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 Education 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 ATTACHED FORMS

Oriskany Central School District

1313 Utica Street
Oriskany, NY 13424

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: **ORISKANY CENTRAL SCHOOL DISTRICT** FOR OFFICE USE ONLY: SID#_____

Student Name: _____
LAST FIRST MIDDLE

Date of Birth: ____/____/____ Birth Place: _____ Current Grade Level: _____
Month Day Year City/State/Country

DIRECTIONS TO PARENT/GUARDIAN: PLEASE ANSWER QUESTIONS 1 AND 2. PLEASE READ THEM BEFORE YOU RESPOND.

Please check(✓) the box that best describes your child. Check(✓) only ONE box.

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 Spanish Culture or origin, regardless of race.

   ☐ YES, Hispanic

   ☐ NO, not Hispanic

Please check(✓) all groups that apply to your child. Please check(✓) at least one box.

2. Please select one or more races from the following 5 racial groups.

   ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples 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.

   ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the 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.

Signature of Parent/Guardian/Foster Parent: _____ Date: _____

Relationship to student (please Check (✓) only ONE box): ☐Mother ☐Father ☐Guardian

☐Other (please specify): _____

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:**
		❑ Male ❑ Female
Month	*Day*	*Year*
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:

Oriskany Central SchoolDistrict
VILLAGE FIELDTRIP AUTHORIZATION

On occasion, it might be necessary or desirable to take an impromptu class field trip somewhere in the village.

My child, while enrolled as a student in the Oriskany Central School District, **DOES** **DOES NOT** have my
(check one)

permission to participate in any and all *Oriskany village trips, sponsored by his/her teacher and/or the principal of the school during the school year. These trips will be either by bus or by walking.

I also give permission for my child's teacher or principal to obtain emergency medical care for my child if necessary during such field trips. If you have any questions, please do not hesitate to contact the school office.

PLEASE COMPLETE INFORMATION BELOW.

Student's Name	Student's Date of Birth
Parent's Name (Please Print)	Student's Doctor
***Parent's Signature**	Doctor's Phone Number
Address	
Home Phone	
Work Phone	
Date Signed	(Student's Special Medical Condition if any)

***This form is only applicable to trips in the Village of Oriskany. Examples: to and from the High School/Elementary School, Village Museum, Firehouse, Library, etc.**

N.A. Walbran Elementary School
EMERGENCY SCHOOL CLOSING PLAN

This is an extremely important letter. There are times when school must close early due to weather or other emergencies. In the event of an emergency school closing, it is impossible for us to contact you individually to determine where your child should be sent. It may also be necessary for us to keep our phone lines open. Therefore:

- You need to have a plan.
- We need to know your plan.
- Your child needs to know what to do.

If the emergency requires immediate evacuation, or in an situation where the roads are impassable, trying to pick up your child may be impossible or be unsafe for you and your child.

The form below provides us information we will need in the event of an emergency. It will be kept with your child's homeroom teacher. The three options are for your child to:

1. Go home or to the babysitter as usual.
2. Take the bus to a prearranged emergency location.
3. Walk to a prearranged emergency location.

If there is a emergency, we cannot call at that time to find out what the emergency plan is for your child. The safety of your child and our staff will best be met if you take the time now to consider this situation. Develop a plan, and make sure your child knows what to do. If on the form below you request that your child get off the bus at another home, please make sure everyone at the other home is aware of this plan too.

Emergency closing announcements are made over the radio and through the phone system. Your cooperation in the development of an emergency plan will help keep everyone safe in case of an emergency. Please call if you have any questions. Make a plan now and review it with your child while you are thinking of it.

EMERGENCY SCHOOL CLOSING PLAN
This form should be returned for EACH of your children. **CHECK JUST ONE**.

IN CASE OF ANY EMERGENCY, MY CHILD IS TO:
_ _Take regular bus home and be dropped off at:
Name_____Phone_____

Address_____

___Take different bus number ___ and get off at the home of:
Name_____Phone_____

Address_____

___Walk to the home of:
Name_____Phone_____

Address_____

Child's name_____ Homeroom Teacher_____

Parent's signature_____ Date_____