Olean City School District
Registration Checklist

Are you living in temporary housing? _____
Are you residents of Olean/ _____ (non-residents pay out of district fees)
Has student attended OCSD before? _____ (We are happy to have you back!)
Are you the child's legal guardian? _____
Does the student have an IEP or 504? _____

Welcome!

Olean High School
(716) 375-8001 Grades 8-12
Olean Intermediate Middle School
(716) 375-8061 Grade 4-7
East View Elementary
(716) 375-8920 Grades Pre-K-3
Washington West Elementary
(716) 375- 8960 Grades Pre-K-3

Questions?

Call Central Registrar,
Jacki Falk
(716) 375-8998
(716) 375-8915
jfalk@oleanschools.org
402 North 7th Street

When you are ready to register, please bring:

- Completed Student Enrollment Packet
- Proof of Age (Examples on Back)
- 3 Proofs of Residency (Examples on back)
  1. _____
  2. _____
  3. _____

When information is compiled and completed, please call Central Registration to submit paperwork:

Homeowners	Renters	Shared Housing	Live out of District
3 Proof of Residency	3 Proof of Residency	Shared housing affidavit & primary resident needs 3 proofs of residency	Superintendent's Secretary receives your registration packet. Attendance is pending acceptance into the district. Out of district fees apply.

Examples of proof of residency

NYS Driver's License
State or Government ID
Voters Registration Card
Mortgage Statement/Purchase Agreement
School Tax Bill
Utility Bill
Current Lease
Landlord Affidavit
Stamped Change of Address Card
Documents from local/state/federal agencies

Examples of proof of age

Birth Certificate
Passport
Driver's License
State/Gov't ID
School ID with DOB
Military ID
Hospital/health records
Consulate ID card
Court order/court issued documents
Native American Tribal documents
Records from non-profit aid agencies

Please note: Documentation confirming residency must be provided to the Central Registrar within three business days of enrollment for residency determination.

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. 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.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female

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

Grade: ____ (preschool-12)

ID#: _____ (optional)

Address: _____

Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check <u>one</u> 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 <u>ANY box other than "In Permanent Housing" is checked</u>, then the student/family should be immediately referred to the MV Liaison. In such cases, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. <u>After</u> 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.

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

DR. GENELLE MORRIS
Superintendent of Schools
(716) 375-8018

OLEAN CITY SCHOOL DISTRICT

410 West Sullivan Street, Olean, New York 14760
General Information: (716) 375-8000
Fax: (716) 375-8047
Website: www.oleanschools.org

JENNY BILOTTA
Business Administrator
(716) 375-8020
jbilotta@oleanschools.org

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of School: _____

Name of Student: _____
Last First Middle

Gender: _____ Male Date of Birth: _____/_____/_____ Grade: _____ ID#: _____
Month Day Year (PreSchool-12) (optional)
_____ Female

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**.)

_____ 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 Parents, Guardian, or Student (For unaccompanied homeless youth)

Date: _____

Olean City School District
410 West Sullivan Street
Olean, New York 14760

Authorization for Release of Academic Information

The student listed below is enrolling at the Olean City School District.

Student Information	
Student Name	
Date of Birth	
Grade	

Last School Attended	
School Name	
Address	

Transcripts & Grades
Current Schedule
Science Lab Folder
Attendance
Discipline

IEP/504
Psychological Evaluation
Speech, OT, PT Scripts
Birth Certificate
Health records including vaccinations

I hereby authorize the release of the records above to the Olean City School District.			
Parent/Guardian Signature		**Date**	

Please email or fax the requested information to:

Jacki Falk, Central Registrar
(716) 375-8998 phone
(716) 375-8915 fax
jfalk@oleanschools.org

Olean City School District
410 West Sullivan Street
Olean, New York 14760

Authorization for Release of Physical & Immunizations

The student listed below is enrolling at the Olean City School District.

Student Information	
Student Name	
Date of Birth	
Grade	

Annual Physical & Vaccination Records

Physician/Provider: _____

City & State: _____

I hereby authorize the release of the records above to the Olean City School District.			
Parent/Guardian Signature		**Date**	

Please email or fax the requested information to:

Jacki Falk, Central Registrar
(716) 375-8998 phone
(716) 375-8915 fax
jfalk@oleanschools.org

Olean City School District
410 West Sullivan Street
Olean, New York 14760

Authorization for Medical Treatment

To Whom It May Concern:
We/I _____

Residing At: _____

In the event I cannot be reached, I do hereby authorize designed agents (building principals and / or school nurses) of the Olean City School District Board of Education, Olean, NY, 14760, to admit and authorize any hospital or medical/physician services be rendered to my child or legal ward
Named: _____

Major surgery would be authorized only if the medical opinion of two (2) licensed physicians or dentists concur the necessity of such surgery.

I understand that the siblings of this child listed below are not covered on this medical release:
Name: _____
Name: _____
This authorization is to be effective from the date the child enters school until the child graduates. It is the parent's responsibility to contact the school with any changes to this form as they occur.

Physician		Allergies	
Dentist		Last Tetanus Shot	
Other Medical Specialists		Religion	
Other health concerns			

SWORN to BEFORE ME ON:
_____/_____/20_____

_____
Notary Public

Please sign in front of a notary or the Central Registrar who is a notary. Picture ID required.

Signed: _____
Parent or Legal Guardian

Olean City School District
Emergency Contact Information

Office Use Only

Dear Parents:
In case your child should become ill in school, or an emergency arises, list the name of a relative or friend we may contact if you are not available.

Child's Name: _____ Grade: _____

Father's

Name: _____
Address: _____
_____

Phone Number: _____
Place of Employment: _____
_____
Work Number: _____

Mother's

Name: _____
Address: _____
_____
Phone Number: _____
Place of Employment: _____
_____
Work Number: _____

Relative or Friend to be Contacted:

Contact Order	Name	Relationship	Phone Number

Please indicate the order in which relative/friends should be contacted after the parents (1st,2nd,3rd,ect)

Emergency / Disaster Information
Please complete this part in case of an emergency / disaster.

In the event of an emergency / disaster, is your child to remain in school after it is safe to go home?
Yes _____ No_____
If your child is to be released, is he/she to go home or to another address:
Home _____ Another Address _____
Please list the name, phone number, and address of where your child is to go (if not home):
Name: _____
Address:_____
Does your child require special medication or diet? Yes _____ No _____
If yes, please specify: _____
Where can parent be reached if not at home?
Work (Place, Phone) _____
Relative / Friend (Name, Phone) _____

Return this form to your child's teacher as soon as possible. Please indicate if the telephone is unlisted to unsure your privacy. Please keep us informed of any changes in the information above so that our records remain updated in order to contact you in any emergency.

Olean City School District
410 West Sullivan Street
Olean, New York 14760

FAMILY HISTORY

STUDENTS NAME: _____
Last First (No Nicknames) Middle

ADDRESS OF RESIDENCE: _____
Street

_____
City State Zip Code

MAILING ADDRESS: _____

(If Different)
CENSUS: # of Adults_____ # of Student _____

PHONE: _____ Emergency Phone: _____

DATE OF BIRTH: _____
Month/Day/Year

PLACE OF BIRTH: _____
City/State/County

E-MAIL ADDRESS: _____

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Father's or Guardian's Name: _____

Father's Current Address: _____
Street City State Zip Code

Occupation: _____ Employer: _____ Phone: _____

Mother's or Guardian's Name: _____

Mother's Current Address: _____
Street City State Zip Code

Occupation: _____ Employer: _____ Phone: _____

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Current Grade of Student (circle one) PS Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12

DR. GENELLE MORRIS
Superintendent of Schools
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OLEAN CITY SCHOOL DISTRICT

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NOTICE REGARD PARENTAL AFFIDAVIT & REGISTRATION OF STUDENTS

In order to attend the schools of the Olean City School District free of charge, a student must be a resident of the District. Students who are not Olean City School District residents are not admitted to the District free of charge.

When you register a student as a resident, you are assuring the District that the student is in face a resident. If this is False, or if the student becomes a non-resident, the student's right to attend in the District will be terminated.

Also, you and any other parent, guardian, or person responsible for the student will be required to pay full tuition for the time the student attended the Olean City Schools as a non-resident.

You and any other parent, guardian, or person responsible for the student must **IMMEDLATELY** inform the Central Registration office if the student's status as a resident changes. Please read and sign the statement below as part of the registration process.

STATEMENT:

I certify that all the information provided on the registration form and other affidavits concerning the residency of both my child (ren) and me is true and accurate.

I also understand that if I provide false information to the Olean City School District that I may be committing the crime of perjury in the third degree and that I may be prosecuted on criminal charges for such false information.

SIGNATURE: _____

PRINT NAME: _____

ADDRESS: _____

DATE: _____

HEALTHY CHILDREN LEARN BETTER

SCHOOL NURSES MAKES IT HAPPEN

Olean City School District Student Health History

Name of Student: _____

Student's Physician: _____ Phone #: _____

HAS STUDENT HAD?	Y/N	IF SO,WHEN	HAS STUDENT HAD?	Y/N	IF SO, WHEN?
ADD?ADHA			Measles		
Allergies			Mental Illness		
Anemia			Migraines		
Asthma			Mononucleosis		
Chicken Pox			Mumps		
Contact with TB			Operations		
Diabetes			Pneumonia		
Diphtheria			Polio		
East Conditions			Rheumatic Fever		
Epilepsy			Scarlet Fever		
Fainting Spells			Seizures		
Frequent Colds			Serious Injury		
German Measles			Sore Throats		
Heart Disease			Tonsillectomy		
Heart Murmur			Tuberculosis		
Hepatitis			Whooping Cough		
High Blood Pressure					

MEDICTIONS

Is student taking any medication? Yes _____ No _____

Will medications be administered by nurse during school hours? Yes _____ No _____

Please list medications: _____

ALLERGIES? If yes, how do they present?

Bee Stings _____
Food _____
Medication _____
Other _____

CHRONIC HEALTH CONDITIONS – If yes, please list

Does student have any chronic health conditions? Yes _____ No _____
(Such as diabetes, heart conditions, kidney disease, musculoskeletal conditions, ect?)
Please list along with special care required for condition: _____
_____

HOSPITALIZATIONS –

Has student ever been hospitalized for illness, injury, or surgery? Yes _____ No _____

EMERGENCY ROOM VISITS –

Has student ever been treated in the emergency room (if different from hospitalization)? Yes _____No _____

Please list
_____

Does student have any vision problem? Yes _____ No _____ _____

Does student wear glasses or contacts? Yes _____ No _____ _____

Does student have any hearing problems? Yes _____ No _____ _____

Are Immunizations up to date (Required for entrance to school)? Yes _____ No _____

Is there any other information you would like the school nurse to know about this student or the student's family_____

_____

OLEAN CITY SCHOOL DISTRICT
EST. 1868
LEADERS OF THE PACK

Signature _____

Relationship _____

Date _____

Olean City School District Student Registration Packet

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your 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 opn 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.

Olean City School District
Committee on Special Education
410 West Sullivan Street
Olean, NY 14760 (716)375-8995

Medicaid Consent

RE: Date:
DOB:
Client Identification Number (CIN):

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

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

I, _____ as the parent/guardian of _____, have received a written notification from the school district/county that explains my federal right regarding the use of public benefits or insurance to pay for certain 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 and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

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

Records to be shared (e.g. records or information about services your child receives, student demographic information):	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Report
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any other Specific Records pertaining to the Student's Services or Program

Student's CIN, if know: _____

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: _____

CHILD CUSTODY DATA:

Child is living with: ( ) Both Parents ( ) Mother ONLY ( ) Father ONLY
( ) Joint Custody ( ) Other: _____
Proof of Custody? _____ YES _____ NO
Custodial Restrictions _____ YES _____ NO; if yes please specify _____
Proof of Custody Restrictions: _____
In Foster Care: _____ YES _____NO; If yes, though which agency _____
Address/Phone of agency if applicable _____
Proof of agency documentation: _____

	Resides with (Circle One)	Salutation (Circle One)	Birth Place/Year City/State/ County	Alive or Decease (Circle One)	Education	Marital Status (Circle One)
FATHER First: _____ MI: _____ Last: _____	YES NO	Mr. Dr. Rev.		Alive Decease		Married Divorced Separated Widowed
MOTHER First: _____ Maiden: _____ Last: _____	YES NO	Miss Mrs. Ms. Dr. Rev.		Alive Decease		Married Divorced Separated Widowed
STEP-FATHER First : _____ Last: _____	YES NO	Mr. Dr. Rev.				
STEP-MOTHER First:_____ Last: _____	YES NO	Miss Mrs. Ms. Dr. Rev.				

Name	Birth Date	Education: Grade in school	Residence: If away from home	School or Occupation	Married	Remarks
BROTHER						
BROTHER						
BROTHER						
SISTER						
SISTER						
SISTER						

RESIDENCY INFORMATION
Complete the residency information below to help the district determine the services the student may be eligible to receive based on the McKinney-Vento Act. 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 reminder of this section.
CHECK ONE BELOW THAT (1) REFLECTS WHERE YOUR CHILD IS PERSENTLY LIVING, OR (2) YOUR LIVING SITUATION IF YOU ARE A YOUTH NOT LIVING WITH A PARENT OR GUARDIAN.
_____ In a Shelter _____ With relatives or others due to lack of housing _____ At a train or bus station, park, or in a car _____ In an abandoned apartment/building _____ In a motel/hotel, camping ground, or other similar situation due to the lack of alternative housing. _____ Temporarily housed in a shelter awaiting DCFS permanent foster care placement
School Principal: If anything is checked, please check with the Homeless Liaison for the district.

Date your child entered grade 9 (if applicable): _____

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Please indicate the former school this child attended:

School Name: _____
School Address: _____
_____
Phone Number: _____

Did your child ever repeat a grade? _____ Yes _____No If yes, which grade(s) _____
Has your child ever attended the Olean City Schools before? _____ Yes _____ No
When? _____ Where? _____

==========

MY CHILD RECEIVED THE FOLLOWING SERVICES:

Was your child classified? _____ Yes _____ No

_____ Remedial Reading
_____ Remedial Math
_____ Special Education Services (Please Specify) _____
_____ Speech Therapy
_____ Physical Therapy
_____ Visual Therapy
_____ Counseling
_____ Resource Room
_____ Other (Please Specify) _____

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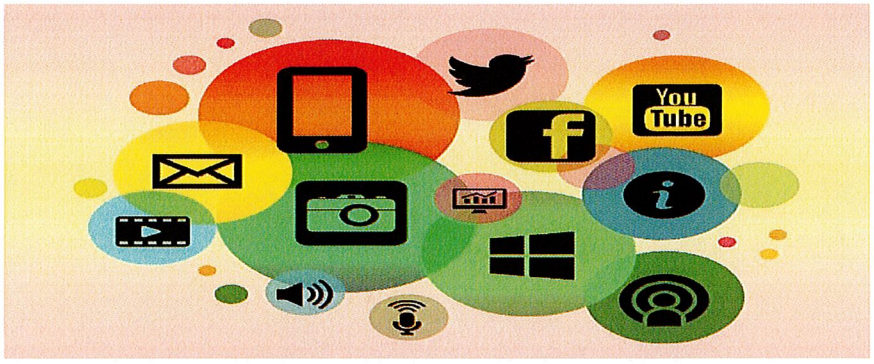
PARENT (GUARDIAN) SIGNATURE: _____

DATE: _____



Olean City School District

Photo Release Form

Dear Parent/ Guardian:

During the school year, we take photographs of school activities involving students to share their achievements and celebrate educational programs. Some photographs may capture your child's participation, directly or indirectly.

These photos may be published through our website, social media pages, school publications, local news outlets, and other avenues.

With this, we seek for your consent in allowing us to publish photos which may involve your child. If you wish to rescind this form at any time, contact the school that your child attends directly.

I grant permission for my child's photo/image to be published by the Olean City School District.	
Child's Name	
Child's Name	
Child's Name	
Child's Name	

Parents Signature _____ Date _____

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

Lissette Colón-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:

Month *Day* *Year*

GENDER:
❑ Male
❑ 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?	❑ 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?	❑ Mother *specify*	❑ Father *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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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

Special Education Right and Resources

Information on the Olean City School District's Special Education Program and other resources can be found on the district's Special Education web page, including contact information, recent notices, and programs/services available under the Committee on Special Education (CSE), Committee on Preschool Special Education (CPSE), and Section 504.

Additional Information defining parents' rights regarding referral and evaluation of their child for purpose of special education services or programs may be found on the New York State Education Department's website at the following address:

http://www.p12.nysed.gov/special/publications/policy/parentguide.htm

Contact Information

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CPSE Chairperson:

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