

Student Registration Checklist

Student Registration Data Packet

Proof of Students Age

- A certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of a baptism) giving the date of birth shall constitute proof of age.
- Where none of the above is available, other documentary or recorded evidence in existence two years or more, except an affidavit of age, may be submitted. Such other evidence may include but not be limited to the following: official driver's license; State or other government issued identification; school photo identification with date of birth; consulate identification card; hospital or health records; military dependent identification card; documents issued by Federal State or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement); court orders or other court issued documents; Native American tribal document; or records from non-profit international aid agencies and voluntary agencies.

Current Physical (not required for initial enrollment, preferred within three days)

Immunization Record (provided before 14 days of enrollment or before 30 days of enrollment if it is known that the student has moved from another country)

Report Card (provided within three days of enrollment; necessary to determine appropriate grade level placement, not for enrollment)

Proof of Residency- The following documentation may be submitted to demonstrate physical presence withing the District (provided within three days of enrollment)

- A copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement;
- A statement by a third party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share the property within the district; which may be either sworn or unsworn; (sample affidavits can be found on the district website);
- Such other statement by a third party relating to the parent(s)' or person(s) in parental relation's physical presence in the district;
- Other forms of documentation that will be considered include but are not limited to
 - Pay stubs; income taxes; utility or other bills;
 - Membership documents (e.g., library cards) based upon residency, voter registration document(s); official driver's license, learner's permit or non-driver identification;
 - State or other government issued identification;
 - Documents issued by Federal, State, or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement); or evidence of

custody of the child, including but not limited to judicial custody orders or guardianship papers.

Pursuant to the Commissioner's Regulations, when a child's parent(s), the person(s) in parental relation to the child or the child, as appropriate, requests enrollment of the child in the District, such child shall be enrolled and shall begin attendance on the next school day, or as soon as practicable, unless a determination of non-residency is made in accordance with the Commissioners Regulations and the Education Law on the date of such request for enrollment. Parent(s), the person(s) in parental relation to the child or the child, as appropriate, shall have up three business days after initial enrollment to submit documentation and/or information in support of the child's residency in the District.

Special Ed – IEP (if applicable)

Somers Central School District
Education Program for Homeless Students

Must be completed by all Registrants

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 do not 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 any that apply or select none of the above)

- in a shelter
- in a motel or hotel
- in a transitional housing program
- in a car, trailer, or campsite
- in a rented trailer/motor home on private property
- in an SRO building (single room occupancy)
- in a rented garage
- temporarily with an adult that is not the parent/legal guardian **due to loss of housing**
- temporarily in another family's house/apartment **due to loss of housing**
- awaiting foster placement
- other places unfit for human habitation
- None of the above

Print Name of parent, guardian, or
Student (for unaccompanied homeless youth)

Signature of parent, guardian, or Student
(of unaccompanied homeless youth)

Date: _____

Somers Central School District
P.O. Box 620
Lincolndale, New York 10540

Student ID# _____
Family ID# _____
(for office use only)

Date: _____

STUDENT REGISTRATION DATA PACKET

Welcome to the Somers Central School District. All of the information requested on this form is required and must be completed before your child can be admitted. If you should have any questions, please feel free to ask.

Student's First Name _____ Middle _____ Last Name _____

Birthdate: _____

Gender: Male Female

Grade last attended: _____

Grade will enter: _____

Counselor: _____

Ethnicity: Hispanic/Latino Yes No

Please select one or more race which best describes the child being registered

American Indian or Alaska Native _____ Asian _____ Black or African American _____

Native Hawaiian or Other Pacific Islander _____ White _____

Is English the primary language spoken in the house? Yes No

Student is living with: Natural Parent(s) (if separated or divorced custody order required)
Legal guardian (guardianship papers required)
Foster Family (foster child data sheet must be completed)

Does your child have an IEP (Individualized Education Plan)? Yes No

Is your child involved with CPSE? Yes No

First Name (Parent 1)	Last Name (Parent 1)	Email Address
First Name (Parent 2)	Last Name (Parent 2)	Email Address
Home Phone	Indicate if telephone is unlisted	Include in Class List
Parent 1 employment phone		Parents 2 employment phone
Parent 1 Cell Phone		Parent 2 Cell Phone
Student Physical Address		
House Number and Street		
City		
State/Zip Code		
Student Mailing Address – P.O. Box		
House Number and Street		
City		
State/Zip Code		
Second Mailing (if required)		
House Number and street		
City		
State/Zip Code		
Emergency Contact Information		
Name		Relationship to Student
Contact Home Phone		Contact Cell Phone
Physician Name		Physician Phone

OTHER CHILDREN IN HOUSEHOLD

Name	Date of Birth	Gender	
		Male	Female

Parent Certification

I affirm that the information given in this student application is complete and accurate. I hereby authorize the Somers Central School District to verify any and all information. Any misrepresentation in residency documentation may result in the removal of my child from the Somers Central School District and/or being held responsible for the payment of tuition to the district

Parent / Guardian Signature

Date



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:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
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?	<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"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<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	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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: 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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
 MO. DAY YR. ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____) - _____ - _____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

Did this child attend a Pre-School Program outside you home?	Yes	No
If yes, was it a half or full day program?	Half	Full

Please place a check by the pre-school program which best describes the one this child attended:

- District Operated
- Day Care Center
- Head Start
- Family or Group Day Care
- Nursery School
- BOCES
- Special Education Pre-School
- Non-public school
- Museum
- Library
- Other

Permission for Release of Student Records

For Kindergarten Registration – Please provide preschool/daycare information

Name of School Previously Attended	
Contact Person	
Address	
City	
State / Zip Code	
Phone Number	
Fax Number	

I hereby request that a copy of all of _____

Student's Name

school record, including psychological, school social work reports and/or Committee on Special Education records and relevant medical records be released and forwarded to the Somers Central School District at the address indicated below.

Parent / Guardian Signature

Date

Check one:

Katie Winter, Principal, Primrose Elementary School, P.O. Box 630, Lincolndale NY 10540

Linda Belger, Principal, Somers Intermediate School, 240 Route 202, Somers, NY 10589

Maryellen Coogan, Guidance Dept., Somers Middle School, 250 Route 202, Somers, NY 10589

Phil Kavanagh, Director of Guidance, Somers High School, P.O. Box 640, Lincolndale, NY 10540

Stacey Elconin, Director of Special Services, Somers School District Office, P.O. Box 620, Lincolndale, NY 10540

Information regarding child's parent or person in parental relation (parent 1)

Name: _____
Home Address: _____
Home Telephone: _____
Employer: _____
Employer Location _____
Employer Telephone _____

Information regarding child's parent or person in parental relation (parent 2)

Name: _____
Home Address: _____
Home Telephone: _____
Employer: _____
Employer Location: _____
Employer Telephone: _____

1. To what extent will the care, custody and control of the child be exercised by:
Please be specific.

The person that the child lives with _____

Either parent _____

2. To what extent is the child's support provided by (a) the person that the child lives with?
(b) either parent? *Please be specific.*

3. If the child is residing in a district other than that of either parent, describe the reason and purpose for such an arrangement including whether both parents have consented to such arrangements. *Please be specific.*

4. Does either parent retain the right to recall the child from the person with whom the child lives?

If so, under what circumstances?

5. Who is to receive school mailings and be contacted in case of an emergency involving the child?

Signature of Parent _____

OR

Signature of Guardian _____

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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: Yes Not Done **Hypertension:** Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Immunization Requirements for School Attendance Medical Exemption Statement for Children 0-18 Years of Age

NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

-
1. Patient's Name _____
 2. Patient's Date of Birth _____
 3. Patient's Address _____
 4. Name of Educational Institution _____
-

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: <http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm>.

Please indicate which vaccine(s) the medical exemption is referring to:

- | | |
|---|---|
| <input type="checkbox"/> Haemophilus Influenzae type b (Hib) | <input type="checkbox"/> Measles, Mumps, and Rubella (MMR) |
| <input type="checkbox"/> Polio (IPV or OPV) | <input type="checkbox"/> Varicella (Chickenpox) |
| <input type="checkbox"/> Hepatitis B (Hep B) | <input type="checkbox"/> Pneumococcal Conjugate Vaccine (PCV) |
| <input type="checkbox"/> Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap) | <input type="checkbox"/> Meningococcal Vaccine (MenACWY) |

Please describe the patient's contraindication(s)/precaution(s) here: _____

Date exemption ends (if applicable) _____

A New York State licensed physician must complete this medical exemption statement and provide their information below:

Name (print) _____ NYS Medical License # _____

Address _____

Telephone _____

Signature _____ Date _____

For Institution Use ONLY: Medical Exemption Status Accepted Not Accepted Date: _____

Somers Central School District
Transportation Request

Please Print

Date: _____

I am hereby requesting bus transportation for _____
Please Print Student Name

who will be attending _____ during the
20____ - 20____ school year.

Male

Female

Grade Level: _____

Date of Birth: _____

Print Name of parent or guardian: _____

Signature of parent or guardian: _____

Street Address: _____

Include a landmark if possible: _____

Mailing Address: _____

Email Address: _____

Home Telephone Number: _____

Work Telephone Number: _____

Cell Phone Number: _____

Starting Date: _____



Dear Somers Parent/Guardian:

The Somers Parent Teacher Association (PTA) would like to welcome your family to our District. If you are interested in being contacted, please give us permission by completing this form. We will provide your contact information to the Somers PTA.

Please Print

Name: _____

Address: _____

Email Address: _____

Telephone Number: _____

Student Name: _____ Grade: _____

Parent/Guardian Signature

Date



Media Opt-Out Form

Only complete this form if you DO NOT want your child to appear in photos and videos taken in the district and schools

Throughout the Somers Central School, we are always looking for ways to celebrate the good work and achievements of our students and staff. Among the ways we recognize these successes is **by publishing photos, videos and articles in a variety of media, including the district website, newsletters, e-blasts, podcasts, social media and our district television programming on Channel 18.** Also, we promote positive news about district happenings to be covered by outside media, including newspapers, magazines, television, radio and electronic media.

If you **DO NOT** wish to have your child participate in these and other forms of publicity, please write your child's name and sign in the space provided below. Please be aware that signing this form limits your child's participation in some grade level and building activities including the fifth-grade slide show, the weekly Primrose Press.

Only complete this form if you DO NOT want your child to appear in photos and videos taken in the district and schools

Child's Name: _____
(Please Print)

Child's School: _____
(Please Print)

Parent/Guardian: _____

Please sign: _____

Date: _____

FOR SCHOOL OFFICE USE ONLY

School Student will be attending

01	02	03	04
SHS	SIS	Primrose	SMS

Residency Information (all information must be current – within the last 3 months)

Lease Deed Mortgage Statement Third Party Affidavit

Landlord/Owner Affidavit

Other: _____

Exception Code (if applicable)

ESL SE Foster Tuition Out-of-District Placement:

Authorized by: _____

School Placement: _____

SCHOOL OFFICE PERSONNEL MUST SIGN BELOW TO VERIFY THAT THEY HAVE CONFIRMED ALL THE INFORMATION GIVEN BY THE PARENT/GUARDIAN REGARDING STUDENT AND RESIDENCY.

School Office Personnel

Date