CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Student Information:

Last Name, First Name, Middle	Nickname	Date of Birth (MM/DD/YEAR)	Gender ◎ Male ◎ Female
Entering Grade Choose one	**Ethnicity** (choose one) ◎ Hispanic/Latino ◎ Not Hispanic/Latino	**Place of Birth** (City/State/Country)	**Primary Language Spoken at Home**

Is the Student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture of origin, regardless of race.

- ☐ Yes, Hispanic
- ☐ No, Not Hispanic

Select one or more races from the following five racial groups. Check all groups that apply to your child. Check at least *one* box.

- ☐ **American Indian or Alaska Native:** A person having origins in any of the original people of North and South America (Including Central America), and who maintains tribal affiliation or community attachment.
- ☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example; Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **Black or African American:** A person having origins in any of the Black racial groups of Africa.
- ☐ **White:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Student's Residential Information

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

Mailing Address if different:

Is this address a temporary living arrangement? ◎ **YES** ◎ **NO**

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

Academic Information:

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

List grade levels repeated:

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

Please describe below any special educational needs of the student:

CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

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

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

Emergency Contacts:

Name	Gender	Relationship	Home Phone #	Work Phone #	Cell Phone #	Pick up from School?
	Choose one					◯ YES ◯ NO
	Choose one					◯ YES ◯ NO

Siblings who will enroll (or are currently enrolled) in Clinton Central Schools:

Name	DOB	Grade	School

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

Parent/Guardian Signature _____ **Date** _____

Directory Information Non-Disclosure Request Form

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

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

Dear Dr. Lee,

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

(Please check off choices below)

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

Parent/Guardian Signature _____ Date _____

CLINTON CENTRAL SCHOOL DISTRICT STUDENT INFORMATION FORM

Student Residency Questionnaire

Student Information:

Last Name, First Name:

Gender: ◯ **Male** ◯ **Female** ◯ **Other (please identify):**

Grade Level: Choose one	**Date of Birth:** (MM/DD/YEAR)	**Age:**

Student Residency:

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

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

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

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

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

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

Parent/Guardian Information:

Last Name, First Name:

Address:

Phone Number:	**Does the child need transportation to and from school? (bus)** ◯ **YES** ◯ **NO**

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

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

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Signature of School Official **Date**

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

_____ McKinney-Vento Liaison Signature _____

Date **Anthony Sirianni, LCSW**

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

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

Date: _____

To: Educational Records Access Officer

Prior School Name _____

Address_____

_____

_____

Fax Number _____

Name: _____ Date of Birth: _____

has enrolled in our school, grade level _____ .

Please send the following:

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

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

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

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

_____
Parent/ Guardian Signature

Clinton Central School District
SchoolTool Parent Portal Access Request Form

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

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

Parent/Guardian name (please print): _____

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

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

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

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

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

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

My email address: _____

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

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

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

Continue to the next page

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

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

_____ I understand that the District's use of the schooltool™ software is supported by technical assistance from the Mohawk Regional Information Center (MORIC), Mindex™ Technologies Inc., and possibly other consultants and employees of these entities. They are instructed to keep any confidential personally-identifiable information, including educational records, they may see in the performance of their duties. I consent to the disclosure of information about me or the student(s) listed above under these circumstances.

_____ I understand that all information stored in the schooltool™ database remains property of the District, and may be accessed, examined, or modified by the District or its vendors at any time.

_____ I understand that the schooltool™ database may record and retain information about when and how I use schooltool™ through the Parent Portal and that this information is the property of the District and subject to review by the District.

_____ I agree that I will not disclose my username and password to any other person, not even other people in my family or household. I accept responsibility for all actions that are performed by anyone gaining access to the schooltool™ database using the username and password assigned to me.

_____ I understand that the District retains the discretion to block my access to schooltool™ whenever it has reasonable suspicion to believe that I have violated one of the aforementioned Terms of accessing schooltool™ and other network resources.

_____ **Date:** _____
Parent/Guardian Name (please print)

_____ **Date:** _____
Parent/Guardian Signature

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

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

New Student Health History

STUDENT INFORMATION:

Last Name, First Name, Middle	Date of Birth (MM/DD/YEAR)	Place of Birth (City/State/Country)

Gender ○ Male ○ Female	Mother's Name	Father's Name

House #, Street Address	Apt. #

City	State	Zip Code	Home Phone #

Number and ages of siblings:

STUDENT HEALTH INFORMATION:

1. **Was your child born prematurely?** ○ **YES** ○ **NO**

2. **Did he/she have any growth or development problems as an infant or young child?** ○ **YES** ○ **NO**

3. **Does your child have any of these health problems? If so, please check and explain.**

- ☐ Ear problems _____
- ☐ Eye problems _____
- ☐ Diabetes _____
- ☐ Headaches _____
- ☐ Hearing Loss _____
- ☐ Heart Condition _____
- ☐ Nosebleeds _____
- ☐ Seizure Disorder _____
- ☐ Other _____

4. **What medications have been prescribed for these episodes? Are the medications taken on a daily or as needed basis?**

- ☐ Medications/Drugs: _____
- ☐ Foods/Plants: _____
- ☐ Bee/Insect Bites: _____
- ☐ Animals/Other: _____
- ☐ Treatment recommended by a physician for allergic response: _____

Is your child receiving allergy shots? ○ **YES** ○ **NO**	Has asthma been diagnosed by a physician? ○ **YES** ○ **NO**

What treatment or medications have been prescribed for these episodes are/or to be taken on a regular basis?

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

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

- ☐ Chicken Pox _____
- ☐ German Measles _____
- ☐ Measles _____
- ☐ Mononucleosis _____
- ☐ Mumps _____
- ☐ Pneumonia _____
- ☐ Scarlet Fever _____
- ☐ Strep throat/multiple infections _____
- ☐ Tuberculosis _____
- ☐ Tuberculosis or a family member (indicate relationship to child) _____

_____

6. Please list specific illnesses, injuries or surgeries:

_____ @ age _____ hospitalized for _____ days

_____ @ age _____ hospitalized for _____ days

_____ @ age _____ hospitalized for _____ days

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

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

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

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

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

For what situation are glasses worn? _____

Are they safety plastic or polycarbonate lenses? _____

Date of most recent vision exam: _____

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

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

13. What school did your child last attend?

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

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

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

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

_____ **Date:** _____

Parent/Guardian Signature:

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE.

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

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

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION:		
Name:	**Gender:** ○ **Male** ○ **Female**	**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 ☐ Other: ☐ 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 ☐ 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 ≥ 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/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

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 and girls grades 5 & 7	Negative	Positive	Referral	
	☐	☐	☐ 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 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.

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. TO BE COMPLETED BY A PARENT OR GUARDIAN:

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

_____ Date: _____

Parent/Guardian Signature:

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

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

Name of student:	Date of birth:
Diagnosis:	
Name of medication:	
Prescribed dosage, frequency, and route of administration:	
Time to be taken during school hours:	
Duration of medication order:	
Possible side effects and adverse reactions (if any):	
Other recommendations:	

_____

Name of licensed prescriber and title (please print):

_____ Date: _____

Prescriber's Signature:

_____ Phone: _____

Address:

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

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

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

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

CLINTON CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

NYSPHSAA Section III

NEW STUDENT ATHLETIC PARTICIPATION FORM

Student: _____ Date: _____

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

Date of last Health Examination (Physical): _____

☐ **Attached Documentation**

New Address: _____

Parents' Name: _____ Telephone: _____

With Whom Are You Living In This District? _____

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

Previous School: _____

Sports Played in Previous School		**Level & Number of Years Played**				
Fall	Sport _____	_____	Modified	_____	JV _____	Varsity
Winter	Sport _____	_____	Modified	_____	JV _____	Varsity
Spring	Sport _____	_____	Modified	_____	JV _____	Varsity

Previous Address: _____

With Whom Did You Live? _____

Reason For Leaving Previous School: _____

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

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

Year Entered 9th Grade: _____ Verification: _____

Counselor's Initials

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

If Yes, which grade: _____

Date of the student's registration accepted: _____

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