WELCOME TO THE
GRAND ISLAND CENTRAL SCHOOL DISTRICT

Committed to Educational Excellence!

All required enrollment forms and related information are included in this registration packet. Forms are to be completed **prior** to registration and brought with you when you enroll your child.

You will also need to bring the following documents:

1. **Original Birth Certificate.** The original will be photocopied by our staff and returned to you immediately.
2. **Proof of Immunization.** The necessary list is enclosed in this packet. We can accept doctor's verification only.
3. **Driver's License** for photo proof only.
4. **Proof of Residency**. A primary and a secondary form of proof are required. Please see "Proof of Residency List" for acceptable forms.
5. In the case of divorce and/or separation, custody papers **MUST** be on file with the district.
6. If you have been awarded guardianship of a child, we require these legal papers for registration.

Once all of these materials are complete, please email it back to centralreg@gicsd.org or contact the District Office at (716)773-8800 x O to schedule a registration appointment.

Grand Island School District Office 1100 Ransom Road Grand Island, NY 14072 Ph: (716) 773-8800 Fax: (716) 773-8843	**Grand Island High School** 1100 Ransom Road Grand Island, NY 14072 Ph: (716) 773-8820 Fax: (716) 773-8951	**Veronica E. Connor Middle School** 1100 Ransom Road Grand Island, NY 14072 Ph: (716) 773-8830 Fax: (716) 773-8983
Huth Road Elementary School 1773 Huth Road Grand Island, NY 14072 Ph: (716) 773-8850 Fax: (716) 773-8984	**Kaegebein Elementary School** 1690 Love Road Grand Island, NY 14072 Ph: (716) 773-8840 Fax: (716) 773-8991	**Sidway Elementary School** 2451 Baseline Road Grand Island, NY 14072 Ph: (716) 773-8870 Fax: (716) 773-8985

GRAND ISLAND CENTRAL SCHOOL DISTRICT
REGISTRATION PACKET CHECKLIST

Student Name: _____

Date of Registration: _____

Expected Start Date: _____

- ❑ Original Birth Certificate
  - ❑ If not a US Citizen - Passport and/or VISA to verify length of stay
- ❑ Proof of Residency (see Proof of Residency List)
  - ❑ Primary
  - ❑ Secondary
- ❑ Proof of custody or Parent Custody Affidavit (if not living with BOTH biological parents)
- ❑ Photo Identification of registering parent/legal guardian
- ❑ DSS-2999 (required for children living in foster care)
- ❑ Registration Form (5 pages)
- ❑ Home Language Questionnaire (2 pages)
- ❑ Release of Records (if transferring from another school district)
- ❑ Migrant Worker Parent Survey
- ❑ New Student Account Request Form
- ❑ Chromebook/iPad Pledge Form
- ❑ Parent Portal Access Request Form
- ❑ Free and Reduced Lunch Application
- ❑ Military Census Form (if applicable)
- ❑ New Enrollment Health History (3 pages)
- ❑ Original Immunization Record
- ❑ Health Certificate Form or Physical (dated within the last 12 months)
- ❑ Dental Health Form
- ❑ Administration of Medication in School

GRAND ISLAND CENTRAL SCHOOL DISTRICT
PROOF OF RESIDENCY

In order to determine if your student is entitled to attend a GICSD school, you must provide a primary and secondary proof of legal residency.

ACCEPTABLE PROOFS OF RESIDENCY

PRIMARY:

- Current lease agreement (must contain the name, address & contact number of the landlord)
- Mortgage statement
- Property tax bill
- Purchase agreement
- Closing documents

SECONDARY:

- Utility bill
- Car registration
- Insurance statement
- Payroll stub showing your address
- Income tax forms
- Voter registration documents
- Bank statement
- US Postal change of address confirmation

Shared housing is defined as two or more families living at one address. Parent/Guardian and student(s) living with another person must complete a Shared Housing Affidavit. Parent/Guardian must obtain a Shared Housing Affidavit from the District Office **PRIOR** to registration. Please contact the District Office at 716-773-8800 for more information.

GRAND ISLAND CENTRAL SCHOOL DISTRICT

STUDENT REGISTRATION

OFFICE USE

DATE		STUDENT ID	
GRADE		SCHOOL	
START DATE		REGISTRERED BY	

STUDENT INFORMATION

LAST NAME, SUFFIX	FIRST NAME	MIDDLE NAME
NICKNAME	**BIRTH DATE**	**GENDER**

PLACE OF BIRTH (CITY, STATE)	IF NOT BORN IN US DATE 1ST ARRIVED

SCHOOL HISTORY

PREVIOUS SCHOOL	GRADE

STREET #	STREET NAME

CITY	STATE	COUNTRY

☐ HAS THE STUDENT ATTENDED GICSD BEFORE? ☐ YES ☐ NO

IF "YES" PROVIDE SCHOOL, GRADE AND YEAR:

SPECIAL EDUCATION SERVICES AND/OR OTHER SERIVES

DOES THE STUDENT CURRENTLY HAVE:

- ☐ Individualized Education Program (IEP)
- ☐ 504 Accommodation Plan
- ☐ Other _____
- ☐ Foster Services
- ☐ Mental Health Services

HOUSEHOLD INFORMATION

HOUSEHOLD LAST NAME	HOME PHONE

STREET #	STREET NAME	APT #

CITY	STATE	ZIP

STUDENT RESIDES WITH:

☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER _____

IF PARENTS ARE DIVORCED OR SEPARATED LEGAL DOCUMENTATION IS REQUIRED.

PARENT/GUARDIAN #1

LAST NAME, SUFFIX	FIRST NAME	MIDDLE NAME

STREET #	STREET NAME	APT #

CITY	STATE	ZIP

CELL #	HOME #	WORK #, EXT

EMAIL ADDRESS	RELATIONSHIP TO STUDENT

PARENT/GUARDIAN #2

LAST NAME, SUFFIX	FIRST NAME	MIDDLE NAME

STREET #	STREET NAME	APT #

CITY	STATE	ZIP

CELL #	HOME #	WORK #, EXT

EMAIL ADDRESS	RELATIONSHIP TO STUDENT

SIBLINGS

PLEASE LIST ALL CHILDREN UNDER THE AGE OF 21 WHO RESIDE IN THIS HOUSEHOLD.

NAME (LAST, FIRST, MIDDLE)	BIRTH DATE	GENDER	GRADE	SCHOOL	RELATIONSHIP TO STUDENT

EMERGENCY CONTACTS

	NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO STUDENT	CELL #	HOME #	WORK #
#3					
#4					
#5					

PHOTO OPT OUT

At times, the students in the GICSD may be interviewed, photographed or recorded during the school day in order to recognize their academic, extracurricular and athletic achievements, to report on the positive work taking place in our schools, to highlight special events, activities and projects, for education purposed, and to educate the community about the district and its schools. This includes but not limited to:

- The District Publications: The Bridge, calendar
- Slideshows at student assemblies and ceremonies
- News releases to local newspaper such as the Dispatch
- The District website and social media: i.e. Twitter, Facebook, Instagram, Snapchat
- Viking Vision

To best protect our students, please select the appropriate box below.

- ☐ I give permission for my child to be interviewed, photographed or recorded during the school day.
- ☐ I do **NOT GIVE PERMISSION** for my child to be interviewed, photographed or recorded during the school day.

Please note, this does not include yearbooks. If you do not wish for your child to be included in yearbooks, please contact your child's school.

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.

PLEASE ANSWER QUESTIONS 1 AND 2. PLEASE READ THEM BEFORE YOU RESPOND.

1. Check the box that best describes the student. Check only ONE box. **Is the student Hispanic, Latino, or of Spanish origin?** (Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.)
   - ☐ **YES**, Hispanic
   - ☐ **NO**, not Hispanic

2. **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:**
   - ☐ **ASIAN:** A person having origins in any of the origins of people of the Far East, Southeast Asia, of the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Island, Thailand, and Vietnam.
   - ☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.
   - ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or the other Pacific Island.
   - ☐ **WHITE:** A person having origins in any of the original places of Europe, North Africa, or the Middle East.

RESIDENCY QUESTIONNAIRE

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.*

☐ Is your current address a temporary living arrangement?
- ☐ YES
- ☐ NO

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

Where is the student currently living? (Please check **ONE** box.)

☐ In permanent housing (homeowner, lease, rental)
☐ In a shelter
☐ With another family or other person because of loss of housing as a result of economic hardship (sometimes referred to as "doubled-up")
☐ In a hotel/motel
☐ In a place not designed for ordinarily sleeping accommodation such as a car, park, bus, train or campsite
☐ Other temporary living situation (Please describe): _____

By signing below, I hereby swear and affirm that the information I have provided in this Student Registration Form is true and accurate and that I have made no misrepresentations of fact. I also acknowledge and understand that the District will seek to recover tuition costs, on a pro rata basis, for any student(s) enrolled in the District's school based on any false representation(s) made herein, and that I agree to be responsible for such tuitions costs, plus interest, including any costs incurred by the District in recovering same.

_____

Parent/Guardian Signature: **Date:**

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:
Month	*Day*	*Year* ❑ Male ❑ 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?	❑ 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:

Grand Island Central School District

1100 Ransom Road, Grand Island, NY 14072
(716) 773-8800
www.grandislandschools.org

CONSENT TO RELEASE EDUCATIONAL RECORDS

To Previous School:

_____

_____

Ph: _____ Fax: _____ Email: _____

I. The undersigned (VI) authorizes *(check as appropriate):*

_____ Release of _____ Copies of _____ Access to

II. Record of _____

_____ _____
Date Date of Birth

III. Records Involved *(check as appropriate):*

_____ Academic _____ Psychological

_____ Standardized Test/State Assessments _____ Attendance

_____ Special Education/504 Records _____ Health

_____ **Please transfer the student's current IEP in IEP Direct to Grand Island Schools**

_____ Other _____

IV.Reason for as Request *(check appropriate):*

_____ Transcript to new school/instruction

_____ Other _____

V. To be released to the **Grand Island Central School District:**

_____ Grand Island High School, 1100 Ransom Road, Grand Island, NY 14072 Fax 716-773-3503

_____ Veronica E. Connor Middle School, 1100 Ransom Road, Grand Island, NY 14072 Fax 716-773-7818

_____ Huth Road Elementary, 1773 Huth Road, Grand Island, NY 14072 Fax 716-773-8984

_____ Kaegebein Elementary, 1690 Love Road, Grand Island, NY 14072 Fax 716-773-8991

_____ Sidway Elementary, 2451 Baseline Road, Grand Island, NY 14072 Fax 716-773-8985

_____ CPSE/CSE, 1100 Ransom Road, Grand Island, NY 14072 Fax 716-773-6279

VI. Signature of Parent or Guardian:

_____ _____
Signature Date

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

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 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 answer 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 by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.

Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____

Teléfono: (_____)-_____-_____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a NYS Migrant Education Program- Identification & Recruitment Office 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020

Grand Island Central School District
Responsible Use Procedure for Technology

Computer Usage:
In order to become a user of the Grand Island Central School District's computer facilities, equipment, and internet accounts, I understand it is necessary to comply with all District regulations for the use of technology as presently enforce and as may be amended from time to time. A violation of the Responsible Use Procedure for Technology may result in the loss of computer privileges, disciplinary action and / or prosecution. I further understand that access to the computer facilities will include filtered access to the Internet.

7315 Student Use of Computerized Information Resources (Acceptable Use Policy)
The Board of Education will provide access to various computerized information resources through the District's computer system ("DCS" hereafter) consisting of software, hardware, computer networks and electronic communications systems. This may include access to electronic mail, so-called "on-line services" and the "Internet." It may include the opportunity for some students to have independent access to the DCS from their home or other remote locations. All use of the DCS, including independent use off school premises, shall be subject to this policy and accompanying regulations. Further, all such use must be in support of education and/or research and consistent with the goals and purposes of the School District.

I understand that individuals and families may be liable for violations of District policies and procedures for such use. While every reasonable effort will be made by school district personnel to monitor proper usage and provide Internet filters to questionable materials, I also accept responsibility for guidance of Internet use – setting and conveying standards for my son/daughter to follow when selecting, sharing or exploring information and media. Internet access is a privilege. Students who abuse the acceptable use of technology on the Internet will be removed from access.

I have reviewed the Grand Island Central School District Responsible Use Procedure for Technology above with my son/daughter. In consideration of the privilege of using the Grand Island Central School District networks and in consideration for having access to the information contained on them and an Internet account, I release the Grand Island Central School District from any claims of any nature arising from my son/daughter's use of the Internet.

Request To Deny Computer Usage:

In order to achieve the career development and occupational learning standards articulated by the New York State Department of Education, students will be provided access to instructional materials and processes only available through the use of computers. I understand that if I do not request, in writing, that my child is not to use computers, an account will be created to facilitate such access.

Student Account Request Form
Grand Island Central School District
Technology Department

Requested Service: ☐ **New Network Account** ☐ **Change Network Account**

☐ **Returning Student**

Section 1 ***Network Accounts***

Student Name (Print):_____

School / Building Attending: _____ Grade Level: _____

Enrollment Date:_____ Student ID: _____

If change is requested, describe change:_____

Parent/Guardian Name (Print): _____

I have reviewed the Grand Island Central School District Responsible Use Procedure for Technology with my son/daughter.

Parent/Guardian Signature:_____ Date:_____

Student Signature (MS/HS only):_____

Section 2 ***Google Apps For Education Account Creation Agreement***

The Grand Island Central School District will provide Google Apps for Education accounts to all students. Students will be able to utilize the account while in school or on another device that has an internet connection. They will also be able to use some of the tools offline. For more information please see the Parent Information document located on our website at http://Grandislandschools.org/cloud.

As a school district, which operates under the Family Educational Rights and Privacy Act (FERPA), we are responsible for obtaining parental consent for the students' use of an Online Service for any student under 18 years of age.

Please indicate that you give permission for your child to have access to Google Apps for Education through the creation of an account.

_____ Yes, I give permission to create an account for my child.

_____No, I do not give permission to create an account for my child.

Please sign below to indicate you have read and agree to the terms of this form.

_____ _____

Parent/Guardian signature Date

Chromebook Use Pledge
for Students and Parents

The following information must be filled out completely prior to obtaining your Chromebook. Failure to complete the following information may delay your Chromebook being issued. **One form per student must be filled out.**

Student Name:_____Student Number: _____

Chromebook Number: _____Grade Level: _____

Parents/Guardians: (initial below)

• ___I have read and discussed the Chromebook Handbook, the Acceptable Use and Insurance Policies with my child. I understand that my child's failure to follow the information and expectations outlined in these documents would result in disciplinary action.

Device Insurance

The Insurance premium is $15/year. The deductible is $20 for the first claim. This premium is non-refundable. Lost or stolen Chromebooks or Accessories are the responsibility of the student/family and must be replaced at full value.

• ___I choose to purchase the Chromebook Insurance.

• ___I choose **not** to purchase the Chromebook Insurance. I understand that I am financially responsible for the cost of repair due to any accidental damage to the Chromebook assigned to my student.

Insurance payment can be paid online through the Infinite Campus Parent Portal or check/cash sent to the District Office.

Parent/Guardian
Signature:_____Date_____

Print Name: _____

Students in Middle School and Up: (initial below)
• ___I have read and understand the Chromebook Handbook & Acceptable Use Policy. I understand that my failure to follow the information and expectations outlined in these documents would result in disciplinary action.

Student Signature_____Date_____

Parent / Guardian Agreement & Access Request Form

Grand Island Central School District

Grand Island Central School District can provide access to student information via the Infinite Campus Portal. In order to protect the confidentiality of student records, all parents/guardians who want to use this service are required to fill out this form and provide verification of identity with photo ID or notarized form.

- I am requesting to review my child(ren) student information on the Grand Island Central School District Infinite Campus Parent Portal.
- I have read the Grand Island Central School District User Expectations for the Infinite Campus Parent Portal and agree to abide by and support the expectations.
- I understand, for the interest of security, the District reserves the right to change user passwords or deny access at anytime.
- By signing this agreement I, as parent/guardian, release the Grand Island Central School District from any and all liability for damages arising out of the unauthorized access to my parent/guardian account.
- I agree that I will not share my password or allow anyone other than myself to use the account including my own child(ren).
- I agree to protect any information printed or transferred to my computer, or destroy the documentation generated from this site.
- I understand that three unsuccessful logins will disable my account. If my account becomes locked I will contact my child's school and request the account to be unlocked. I will provide the "Personal Login ID" given to me at the time the account was created and answer any questions to verify my identity. In the sole discretion of the District, the account may be unlocked, but I understand that it may take up to 3 – 5 schools days to have my account unlocked.
- I have checked that the computer I will be using to access the Internet site for viewing student information meets or exceeds the minimum requirements as identified on the Grand Island Central School District Web site.

List the names of all your child(ren) currently enrolled in Grand Island Central School District and residing at the address listed below. The information given on this form must match the enrollment information you provided during registration.

PLEASE PRINT

Parent / Guardian Name (**one name per form**): _____

Parent / Guardian Home Address: _____

Parent / Guardian Email Address: _____

Parent / Guardian Home Telephone Number: ( ) _____

Each parent will only need one login for all children/all schools. Parents that are also GICSD employees will use their GICSD login.

Please list all children in the household who you are the Parent /Guardian of and will be enrolled in GICSD.

Child's First Name	Child's Last Name	Child's Date of Birth	School Attending	Student ID# (to be completed by school)

Parent / Guardian Signature _____ Date _____ Please Print Parent / Guardian Name _____

The school principal, secretary or designee must witness the parents signing this form. **The parent must provide a photo ID prior to signing.** If the parent cannot visit the school, a notary public must witness the parent signing the form and use their public seal with a current date.

School Witness or Notary Public Official Witnessing Parent / Guardian Signature _____

Notary Public

Date _____ Date Commission Expires _____

If notarized return form to 1100 Ransom Rd, Grand Island, NY 14072 Technology Department

Office Use Only:

Date Returned: _____ ☐ ID Verified Form & ID Checked by: _____

☐ Activation Key Provided Date Key Provided _____ Initials

GUID number _____

3/6/2014

ACTIVE DUTY CENSUS FORM

New York State Education Department is asking school districts to identify any student where one or more parent/legal guardian is a member of the Armed Forces and on active duty. The Armed Forces include the Army, Navy, Air Force, Marine Corps, Coast Guard, or full-time National Guard. Active duty means full-time duty in the active military service of the United States. Such terms include full-time training duty, annual training duty and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the Military Department concerned.

If this describes any parent or guardian of a student, please fill out the form below.

Student Name: _____

Student ID Number: _____

Student Grade: _____

Name of Service Member: _____

Branch of Service: _____

Active Duty Date: _____

Active Duty End Date (if known): _____

Revised 07/27/2023

GRAND ISLAND CENTRAL SCHOOL DISTRICT

** 2025-2026 SCHOOL YEAR **

Health and Dental Examination Requirements

Dear Parents/Guardians,

1. New York State law requires a health examination for all students **entering the school district for the first time and <u>when entering Pre-K or K, Grade 1, Grade 3, Grade 5, Grade 7, Grade 9 and Grade 11</u>**. The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner. Including Body Mass Index and Weight Status Category.

2. A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. This is a request, **NOT a requirement.**

- A copy of the health examination must be provided to the school within **30 days** of being **new to the district,** and when your child **begins Pre-K or K, and Grades 1, 3, 5, 7, 9 and 11.** If a copy is not given to the school within 30 days, the school will be contacting you.
- If your child has an appointment for a physical exam during this school year that is after the first 30 days of school, please notify the Health Office with the date for our records.
- Physical exam forms and dental certificate can be found on the district's website at www.grandislandschools.org under Departments & Services/Health Services/Health Forms
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. A copy of each of these forms is attached for your convenience. Forms may also be faxed to the confidential numbers below:

Sincerely,

School Health Services:

Charlotte Sidway Elementary	Phone: 716.773.8870 x2	**Fax: 716.773.8842**
Huth Road Elementary	Phone: 716.404.1706	**Fax 716 773 8764**
Kaegebein Elementary	Phone: 716.404.1606	**Fax: 716.773.8765**
Veronica Connor Middle School	Phone: 716.773.8838	**Fax: 716.773.8841**
Grand Island High School	Phone: 716.773.8827	**Fax: 716.773.9049**

3/2025

Grand Island Central School District
New Enrollment Health History

Dear Parent/Guardian:

Please complete this form so that we may be able to generate a cumulative health record for your child. This information is confidential and will only be shared with appropriate school personnel. I hereby give my permission for this information to be shared with appropriate school personnel as needed.

Signature Parent/Guardian: _____ Date: _____

Student's Last Name: _____ First Name: _____

Address: _____ Home Phone: _____

Date of Birth: _____ Grade: _____

Did this student previously attend a Grand Island school? ❑ Yes ❑ No

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

New York State law requires all <u>NEW STUDENTS</u> entering a school district for the first time have a physical examination completed no more than 12 months prior to the entry of school.

Please check one of the following:

I give permission for my child to receive a physical at school by the school physician

My child has an appointment scheduled for a physical on _____

My child had a physical within the past 12 months on _____

(If this option is checked, **<u>please return the completed physical form and copy of immunizations within 30 days of starting school)</u>**

Signature Parent/Guardian _____ Date _____

Student's History:

Does your child require special shoes, braces, crutches, wheelchair, diet, or have impaired function? ❑ Yes ❑ No

If so, please explain: _____

Is there a history of any hospitalizations, significant injuries (including broken bones) or surgery? ❑ Yes ❑ No

If so, please explain: _____

Does your child have any congenital abnormalities or defects? ❑ Yes ❑ No

If so, please explain: _____

Student's History (continued)

Has student ever been , or currently being followed by a doctor or clinic for any health problems? Yes No

If so, please describe: _____

Is there any mental, emotional or physical condition the school should know about? Yes No

If so, please describe: _____

Does this student have any known allergies? *(insects, pets, foods, medication, seasonal, environmental)* Yes No

If so, please describe: _____

Has the allergy required emergency treatment or does the student require emergency medication? Yes No

If so, please explain: _____

Does this student currently take medication on a regular basis? Yes No

If so, for what reason? _____

Medication and Dosage: _____ Is it necessary for school? Yes No

Medication and Dosage: _____ Is it necessary for school? Yes No

Please check all that apply and provide dates where necessary:

Neurologic Concerns
- Head Injury/Concussion
- Loss of Consciousness / Fainting
- Convulsions / Fits
- Seizures
- Staring Spells
- Migraines
- Other:

Cardiac Concerns
- Heart Murmur
- Heart Arrhythmia
- Other:

Respiratory Concerns
- Asthma
- Bronchitis
- Pneumonia
- Reactive Airway Disease
- Other:

- Anemia
- Bladder/Bowel Problems
- Diabetes
- Hard to stop bleeding

Hearing Problems
- History of Infections
- Tubes
- Hearing Loss
- Wears Aids/ Uses FM System

Vision Problems
- Glasses
- Eyes Patched
- Eye Exercises
- Amblyopia (Lazy Eye)
- Color Perception Deficiency

Please list any additional comments or information: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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	Date
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ 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 Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY 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: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Grand Island Central School District

School Health Services

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. MUST BE COMPLETED BY THE LICENSED HEALTHCARE PRESCRIBER:

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

Name of Student: _____ DOB: _____

DIAGNOSIS CODE: _____ Duration of Treatment: _____ ( ) Entire school year

(REQUIRED)* _____ *Order may extend to a summer school session if needed ( ) Yes ( ) No*

MEDICATION	*DOSAGE*	*ROUTE*	*FREQUENCY/TIME TO BE TAKEN*

Possible Side Effects and Adverse Reactions (if any): _____

( ) I deem this child to be a ***nurse-dependent student*** and understand that administration of oral, topical, inhalant and injectable medications must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician or parent.

( ) I deem this child to be a ***supervised student*** and understand that the school nurse, or other designated person in the case of the absence of the school nurse, ***may*** administer the medication ***upon request and at the direction of the student***, including field trips.

( ) ***I deem this child to be an independent student who can self-administer his or her own medication(s) without any assistance.***

Name of Healthcare Prescriber _____ *Date* _____

Prescriber's Signature _____ *Phone* _____

NPI License # _____

(REQUIRED) ***(MAY USE STAMP)***

B. MUST BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child receive the medication as prescribed above by our licensed healthcare prescriber. I will furnish the medication in the properly labeled pharmacy container for prescription medication, or in the manufacturer's labeled container for over-the-counter medication. I understand that the school nurse will administer the medication to my child as prescribed above. Under certain circumstances, such as a field trip where no nurse is present, an adult will supervise my supervised student taking his/her own medication. I have read and will comply with the procedures for administering medications on the back of this form.

Signature (Parent or Guardian) _____ *Date* _____

Preferred Telephone: Home _____ *Cell* _____ *Work* _____

** PLEASE SEE REVERSE ON PROCEDURES FOR ADMINISTERING MEDICATION **

Revised 3/19/20

Grand Island Central School District

School Health Services

Procedures for Administering Medications

Only those medications which are necessary to maintain the student in school and which must be given during school hours should be administered. Any student who is required to take medication during the regular school day or while participating in school-sponsored activities (e.g., field trips, athletics) should comply with all procedures.

The following procedures for administering medications must be followed to provide safeguards and protection for your child's health. This policy has been implemented district wide. Your school nurse must follow these district regulations for any student who takes medication during the school day.

- **Medication must be brought to school by the parent.** Students are not permitted to transport prescription or over-the-counter medication to school. It must be kept in a container appropriately labeled (by the pharmacy and/or licensed healthcare prescriber). Parents may obtain two labeled containers from the pharmacy, one for home and one for school.

- **Written orders signed by a licensed healthcare prescriber and instructions by the pharmacist must accompany the medication.** These instructions must include the student's name, the name of the medication, the dosage, the route (the way it is to be given), frequency, duration, and any possible side effects. A copy of the prescription and over-the-counter medication request form is available in the Health Office and on the district's website.

- Written permission from the parent must be submitted and kept on record in the Health Office requesting that the school district comply with the licensed healthcare prescriber's signed medication orders.

- **These procedures must be followed for all prescription and all over-the-counter medications.** <u>This includes all cough drops, lozenges, lip balms, skin creams, analgesics, etc.</u> Over–the-counter medications must be in a manufacturer's labeled container.

- During field trips or other school activities, the school nurse will advise classroom teachers in regards to procedures.

- When purchasing Diphenhydramine (otherwise known as Benadryl) as prescribed by your healthcare provider, please consider buying tablets or fastmelts rather than liquid (for easier transport during field trips)

- Students assessed by their licensed healthcare provider as being an ***<u>independent student</u>*** may carry and self-administer an inhaler or epi-pen.

- ***<u>Supervised</u>*** students may carry and use their sunscreen at school as long as they have written permission from the parent or guardian to carry and use sunscreen. ***<u>Supervised</u>*** means they are able to recognize that it's sunscreen, know why they are using it, and are able to independently apply the sunscreen. **(does not apply to Sidway students)**

- Any medication that is not picked up by an adult at the end of the school year will be discarded by the school nurse, as per New York State guidelines.

- **These procedures will be strictly enforced for your child's protection**

Revised and approved by Dr. Ehlenfield 6/2013

(3/2018)

Dental Health Certificate

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.

Grand Island CSD
Committee on Special Education
1100 Ransom Road
Grand Island, NY 14072
((716) 773-8815)

Dear Parent/Guardian:

Grand Island offers their students many related services such as Physical Therapy, Occupational Therapy, Speech, Vision, Hearing, Psychological Counseling to name a few. NYS will reimburse us for a small portion of the cost we pay to provide these services if the student is NYS Medicaid. We must have a signed consent from the parent with the child's Medicaid number on it as proof they are a Medicaid recipient.

If your child receives Medicaid, please fill out the attached form with child's Medicaid number and sign it. If your child is not Medicaid eligible, please check that box, sign and return to our office.

You may mail it to the address above or email it to deborahlongo@gicsd.org. Please contact Debbie Longo at 404-1214 with any concerns or questions you may have.

Sincerely,

Cheryl M. Cardone

Cheryl M. Cardone
Asst. Superintendent of Pupil Personnel Services

GRAND ISLAND CSD
Medicaid Consent

This is to ask your permission (consent) to bill your child's Medicaid Insurance Program for special education and related services that are on your child's Individualized Education Plan (IEP). This consent allows the Grand Island CSD to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I,_____ the parent/guardian of _____have received a written notification from the Grand Island CSD that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the Grand Island CSD may access Medicaid to pay for special education and related services provided to my child, and that this consent extends to any eligible services provided in prior school years.

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; I have the right to withdraw consent at any time; and the Grand Island CSD must give me annual written notification of my rights regarding this consent.

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

Records to be shared (such as records or information about services your child receives)
IEP
Written Order/Referral
Evaluation Reports
Session Notes
Medication Administration Report
Special Transportation Log
Other Personally Identifiable Information
Any Other Specific Records Pertaining to the Student's Services or Program

☐ 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.

☐ My child is not Medicaid eligible.

MEDICAID ID #_____

Parent/Guardian Signature:_____

Print Name:_____ Date:_____

INFORMATION ABOUT SPECIAL EDUCATION UPON ENTRY TO SCHOOL
Chapter 434 of the Laws of 2014

Statute: Section 4402
Effective Date: July 1, 2015

Summary:

This amendment requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification shall be provided to the parents of all students in the district (with and without disabilities) upon their child's entry into public school. Districts may provide this information to parents by directing them to A Parent's Guide to Special Education on the New York State Education Department's (NYSED's) web site, provided that the district includes the name and contact information of the district's Committee on Special Education chairperson or other appropriate special education administrator. NYSED's A Parent's Guide to Special Education is available in both English and Spanish.

English: https://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm
Spanish: https://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm

Statute: Chapter 434 of the Laws of 2014

Section 1. Section 4402 of the education law is amended by adding a new subdivision 8 to read as follows:

8. Upon their child's enrollment or attendance in a public school, such school shall notify every parent or person in parental relation of their rights regarding referral and evaluation of their child for the purposes of special education services or programs pursuant to applicable federal and state laws. Such notification may be provided by directing parents or persons in parental relation to obtain information located on the department's website relating to a parent's guide to special education in New York state for children ages three through twenty-one provided the notification shall also contain the name and contact information for the chairperson of the school district's committee on special education or other individual who is charged with processing referrals to the committee in the district.

§ 2. This act shall take effect July 1, 2015. Effective immediately, the addition, amendment and/or repeal of any rules or regulations necessary for the implementation of this act on its effective date are authorized to be made on or before such date.

Grand Island Central School District

1100 Ransom Road, Grand Island, NY 14072
(716) 773-8800 Fax: (716) 773-6279
www.grandislandschools.org

January, 2023

Dear Parent/Guardian:

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student educational records. Educational records subject to this protection include all academic, attendance, health, guidance and special service reports. FERPA requires schools to inform parents and students annually of these rights, such as by this notice for the current school year. Under FERPA, parents and students over 18 years of age ("eligible students") have the following rights:

(1) Parents and eligible students have the right to inspect and review the student's educational records within 45 days from the date in which the school receives a request for access.

Parents or eligible students who wish to review their records should submit a written request that identifies the record(s) they wish to inspect to the school principal or other appropriate "school official." A "school official" is a person employed by the district as an administrator, supervisor, instructor or support staff (including health or medical staff and law enforcement personnel), school board member, or a person or company with whom the district has contracted to perform a specific task (such as attorney, auditor, medical consultant, therapist or evaluator.

After processing the written request for inspection of a student's education records, the school official will make arrangements for the access and notify the parent or eligible student of the time and the place where the records may be inspected. A copy fee of $0.25 per page may be charged provided that such fee does not effectively prevent parents or eligible students from exercising their rights to inspect and review these records.

(2) Parents and eligible students have the right to request the amendment of the student's educational records that the parent or eligible student believes to be inaccurate, misleading or otherwise in violation of the student's privacy rights under FERPA.

Parents or eligible students who seek to amend a record should submit a written request to the school principal which clearly identifies the part of the record they want changed, and why it is incorrect or misleading. If the school decides not to amend the record as requested by the parent or eligible student, the school will notify the parent or eligible student of the decision and advise them of their right to a hearing and their right to file a complaint with the Family Policy Compliance Office at the U.S. Department of Education. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

Please note that the school is not required to consider requests for amendment under FERPA that: (1) seek to change a grade or disciplinary decision; (2) seek to change opinions or reflections of a school official or other person reflected in an education record; or (3) seek to change a determination with respect to a child's status under special education programs.

(3) Parents and eligible students have the right to consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without their consent.

Generally, schools must have written permission/consent from the parent or eligible student in order to release any information from a student's education records. However, FERPA allows schools to disclose records, *without consent*, to the following parties or under the following conditions:

- to a school official with a legitimate educational interest (i.e., the official needs the record to fulfill his or her professional responsibility);

- to another school district to which the student seeks or intends to enroll;
- to specified officials for audit or evaluation purposes;
- to appropriate parties in connection with financial aid to a student;
- to organizations conducting certain studies on behalf of the school;
- to accrediting organizations;
- to comply with a judicial order or lawfully issued subpoena;
- to appropriate officials in cases of health and safety emergencies; and
- to state and local authorities, within the juvenile justice system, pursuant to specific State law.

In addition, schools are also permitted to release information, without prior written consent of the parents or eligible student, which has been appropriately designated as "directory information" by the district. Grand Island Central School District has designed the following information as "directory information":

- student's name
- address
- telephone listing
- participation in officially recognized activities and sports
- weight and height of members of athletic teams
- photograph
- degrees, honors and awards received
- date and place of birth
- grade level
- enrollment status
- the school most recently previously attended if not Grand Island

NOTE: Specific examples include honor roll, merit roll, annual yearbook, playbills and graduation programs.

Photo/directory information, which is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, two federal laws require local educational agencies (LEAs) such as Grand Island Central School District to provide military recruiters, upon request, with three photo/directory information categories – names, addresses and telephone listings – unless parents have advised the LEA that they do not want their student's information disclosed without their prior written consent.

If you do not want Grand Island Central School District to disclose "photo/directory information" from your child's education records, you must notify the building principal in writing that you do not want "photo/directory information" disclosed. The written notice to the principal about photo/directory information must be received no later than 14 days after the date of publication of the notice (or within 15 days of newly enrolling in the district). A notice is provided below.

(4) Parents and eligible students have the right to file a complaint with the U.S. Department of Education concerning alleged failures by the Grand Island Central School District to comply with the requirements of FERPA.

The name and address of the Office that administers FERPA are:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-5920

Additional information on local school policy may be obtained from building principals or Pupil Services at Grand Island Central School District, 1100 Ransom Road, Grand Island, New York 14072.

Sincerely,

Brian Graham, Ed.D.
Superintendent of Schools

nystateofhealth
The Official Health Plan Marketplace

Child Health Plus
New York State's Health Plan for Kids

Child Health Plus At a Glance

WHO IS ELIGIBLE?

CHILDREN WHO ARE:

- Under age 19
- New York State residents
- Not eligible for Medicaid
- Not covered by other health insurance
- Not eligible for or enrolled in health coverage through a state health benefits program (NYSHIP)
- Children may be eligible regardless of immigration status

NY State of Health complies with applicable Federal civil rights laws and state laws, and does not discriminate on the basis of race, color, national origin, creed/religion, sex, age, marital/family status, arrest record, criminal conviction(s), gender identity, sexual orientation, predisposing genetic characteristics, military status, domestic violence victim status and/or retaliation.

WHAT'S COVERED?

- Well-child visits
- Physical exams
- Immunizations
- Inpatient hospital/ surgical care
- Lab and imaging services
- Dental and Vision Services
- Emergency services
- Short-term physical and occupational therapy
- Prescription and Non-Prescription drugs, if ordered by a licensed professional
- Therapeutic outpatient services (chemotherapy, hemodialysis)
- Inpatient and outpatient mental health, alcohol and substance use services
- Speech and Hearing Services

This is not an all-inclusive list of covered benefits. You should contact your health plan directly for any questions about services and benefits covered through your health plan and providers.

CONTACT US:

nystateofhealth.ny.gov | 1-855-355-5777 or TTY 1-800-662-1220

Si usted habla un idioma diferente al inglés, los servicios de asistencia de idioma están disponibles gratis para usted. Llame al 1-855-355-5777 (TTY: 1-800-662-1220).

如果您使用的語言不是英語，您可以使用我們的免費語言支援服務。請致電 1-855-355-5777 (TTY: 1-800-662-1220)。

HOW MUCH DOES A CHILD HEALTH PLUS PLAN COST?

MONTHLY PREMIUMS: Monthly price depends on household income and family size.* There is no monthly premium for families with lower incomes. Families with higher incomes pay a monthly premium, according to the chart below. For larger families, the monthly fee is capped at three children. Families with incomes above the level for subsidized coverage may pay the full premium, which varies by participating health plan.

COST SHARING: Child Health Plus has no annual deductible and no co-payments.

Maximum Annual Income by Family Size				Monthly Family Contribution Per Child (max number of children you pay for is 3)
1	2	3	4	
$32,368	$43,779	$55,190	$66,600	$0
$36,450	$49,300	$62,150	$75,000	$15 (max $45)
$43,740	$59,160	$74,580	$90,000	$30 (max $90)
$51,030	$69,020	$87,010	$105,000	$45 (max $135)
$58,320	$78,880	$99,440	$120,000	$60 (max $180)
over $58,320	over $78,880	over $99,440	over $120,000	Full premium, varies by health plan (no family max)

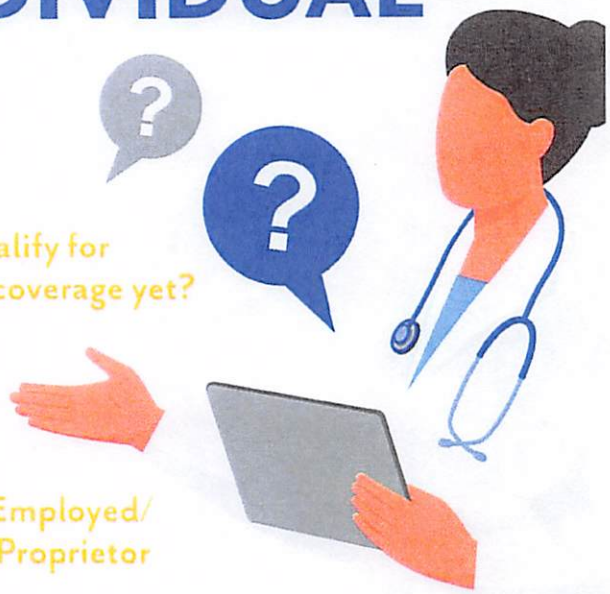
*Based on 2023 Federal Poverty Levels (FPL). Income Levels may be adjusted each year based on FPL changes.

Lawley | INDIVIDUAL & SENIOR HEALTH INSURANCE

TOP 50 NATIONAL BROKER
BUSINESS INSURANCE®

WHY MIGHT YOU ENROLL IN THE INDIVIDUAL MARKETPLACE?

KNOW YOUR OPTIONS



Is this YOU?

- Retiring, but under 65?
- Losing health coverage?
- Do not qualify for employer coverage yet?
- Enrolling into Medicare, but your spouse is not eligible?
- Have children who are aging off the family health plan?
- Self Employed/ Sole Proprietor

Did you know that when retiring, COBRA is not your only option?

Most of us know that COBRA is an expensive option and is not forever. There are various options for individuals to obtain health insurance, whether it be by enrolling directly with a local insurance carrier or enrolling on the NYSOH Marketplace. We are here to help you explore your options.

- You could qualify for a tax credit on the NYSOH Marketplace.
- Your children could qualify for Child Health Plus, which is great for cost-control.
- Easy transition from individual coverage to Medicare coverage.
- Assistance with understanding your premiums, plan benefits & more.

From traditional marketplace insurance to Medicare, I am happy to work with you to find the healthcare protection that works best for you and your family.

Call to schedule a FREE one-on-one or virtual meeting!

YOUR INSURANCE CONSULTANT

MARIAH MOONAN

Individual & Senior Health Insurance

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716.849.1595

THERE IS NEVER A FEE TO MEET WITH ME!

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