

NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT

Student Registration Form

Student Name: _____ Preferred/Identified Name: _____
Last First Middle

Student ID: _____ Grade: _____

Student DOB: _____ Gender: Male Female Nonbinary

Proof of Residency: _____ Proof of Age: _____

Residence Address: _____
House number street name apt or lot #

City state zip code County

Mailing Address (if different from Residence): _____
PO Box

City state zip code

Student resides with: Both Mother & Father Mother Only Father Only
 Legal Guardian (specify relationship to child) _____

Is there a custody order or separation agreement that governs custody of this child? Yes No
If yes, please provide documentation.

Information on Parent/Guardian Living at Above Address	1 st Adult Parent/Guardian Living at Above Address	2 nd Adult Parent/Guardian Living at Above Address
Relationship to Child	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent Other _____	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent Other _____
Parent/Guardian Name	First _____ Last _____	First _____ Last _____
Home Telephone Number		
Cell Phone Number		
Work Telephone		
Email Address		
Information on Parent/Guardian NOT Living at Above Address	1 st Adult Parent/Guardian NOT Living at Above Address	2 nd Adult Parent/Guardian NOT Living at Above Address
Relationship to Child	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent Other _____	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent Other _____
Parent/Guardian Name	First _____ Last _____	First _____ Last _____
Home Telephone Number		
Cell Phone Number		

NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT

Student Registration Form

Student Name: _____

Work Telephone		
Email Address		
Okay to Pick up:	YES _____ NO _____	YES _____ NO _____
Receives Mailings:	YES _____ NO _____	YES _____ NO _____

Please enter the name and information for all other individuals living in the household.

First & Last Name	DOB (if a minor)	Grade (if applicable)	School (if applicable)	Relationship to Child

Previous School Information

Name of Last School Attended _____

District Name and Address _____

Years/Grades in Attendance _____

Has this student ever attended North Rose-Wolcott Central School District before? ___ YES ___ NO

If YES, what year/grade did they attend _____

Has this student ever attended school in New York State before? ___ YES ___ NO

If YES, please specify: School(s): _____ Grade(s): _____ Year(s): _____

School(s): _____ Grade(s): _____ Year(s): _____

Is this student currently enrolled in any type of Special Education or Support Programs (e.g., resource room, speech/language, English as a Second Language, etc.)? ___ YES ___ NO

Does your child have a 504 plan? ___ YES ___ NO

Does your child have an Individualized Education Plan (IEP)? ___ YES ___ NO

NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT

Student Registration Form

Student Name: _____

It is mandated, in case a parent or legal guardian cannot be reached during the school days, to give the names of two emergency contacts who will come for and take care of your child should they become ill or injured during the school day. All attempts will be made to reach parents/guardians first. If they are not reachable, the school will attempt to reach the emergency contacts below:

Adults other than Parents/Guardians	First Emergency Contact	Second Emergency Contact
Emergency Contact Name	First _____ Last _____	First _____ Last _____
Contact Telephone (xxx-xxx-xxxx)		
Cell Phone (xxx-xxx-xxxx)		
Relationship to Child		

If school closes early for an emergency situation, my child _____ **SHOULD** _____ **SHOULD NOT** go home. If they are not to go home, please specify where they are to go below.

Name of Person _____ Phone # _____

Address _____

If you have a caregiver (where your child goes on a daily basis), please complete the following information below:

Caregiver Name _____ Phone # _____

Address _____

NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT

Student Registration Form

Student Name: _____

McKinney-Vento Act – Residency Questionnaire

Student Name: _____
Last First Middle

Student ID: _____ Grade: _____

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

Complete these questions:

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 box.

If you answered NO to the above questions, you may stop here.

___ in a shelter _____ with relatives or others due to lack of housing

___ at a train or bus station, park or in a car _____ in an abandoned building

___ in a motel/hotel, camping ground, or other similar situation due to the lack of alternative, adequate housing

___ Other temporary living situation (please describe):

Please sign and date the completed registration form and return to the appropriate office.

Signature of person completing form Print Name Date

Student Demographic Information

To the Parent/Guardian: The U.S. Department of Education requires the collection and recording of demographic information, including the ethnic identity of students. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

This information will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Directions to Parent/Guardian: Please complete this form and answer questions (1), (2), and (3). Please read them before you respond.

Student Name: _____

1. **Student's place of birth** (city, state, and country): _____
2. **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 or origin, regardless of race.
 YES, Hispanic. NO, not Hispanic.
3. **Select one or more races from the following five racial groups** (check all that apply):
 - American Indian or Alaska Native:** A person having origins in any of the original peoples of North America and South America (including Central American), and who maintains tribal affiliation or community recognition.
 - Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
 - Black:** 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 other Pacific Islands.
 - White:** a person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian/Other

Date

Relationship to Student (please check one box below)

- Mother Father Guardian Other (Specify): _____

All students between 5 and 21 years of age, and who have not received a high school diploma, 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.



North Rose - Wolcott Central School District
 10486 Salter Rd
 North Rose, NY 14516
 Transportation Department
 315-587-2905

2025-26 Alternate Transportation Request

- NRW Elementary NRW High
 NRW Middle Other (school name) _____

Student(s) Information: (Please print)

First & Last Name	Birth Date	Grade Level
_____	_____	_____
_____	_____	_____

_____ Please check if new home address

Home Street Address, including Zip Code

Alternate Location or Daycare Information: (Please print)

_____	_____
Street Address	Telephone number
_____	_____
Caregiver Name	Alternate telephone number

Mark appropriate boxes

	Mon	Tues	Wed	Thurs	Fri
To School					
From School					

_____ Desired start date

Transportation will be arranged to/from alternate location at times marked above. All other times student will be transported to/from the home address in student information section above.

If you plan to drop your student off each morning, please indicate in the boxes above with the abbreviation (PDO), if you plan to pick your child up in the afternoon please indicate in the boxes above with the abbreviation (PPU).

Parent/Guardian Information: (Please print)

_____	_____	_____
Name (print)	Home Telephone	Alternate number

My signature certifies that I am the parent/legal guardian of the above student(s) and authorized to request transportation to/from the alternate location/child care provider listed above.

Signature: _____ Date: _____

***Please allow 2 business days for change.**

Print, complete, and mail, Email, or Fax to North Rose Wolcott Transportation
SThomas@nrwcs.org or CYates@nrwcs.org
 Fax: (315)587-2906

Subject: CHILDCARE TRANSPORTATION

The North Rose-Wolcott Central School District recognizes the need to accommodate transportation requests for district students to be transported to and/or from an address other than their home. These requests should be necessitated by a working parents need to provide for childcare service before and/or after normal school hours. Childcare transportation requests will be approved if they meet the following criteria:

- a) Childcare transportation will be available to students in grade K through 8.
- b) A child must be eligible for transportation according to the transportation eligibility policy in order to be transported to or from a childcare provider.
- c) The childcare provider must be located within the North Rose-Wolcott Central School District and on an already existing bus route. Door-to-door bus service will not necessarily be provided. New bus routes will not be created and already established bus routes will not be altered.
- d) Transportation must be consistent week to week. A child's daily schedule for pick-up and drop-off may be different each day of the week with a maximum of two (2) pickup and two (2) drop off points for the week. For example, a child may go to daycare Monday, Wednesday and Friday and home the other two (2) days. The schedule must remain the same every week for the entire school year.
- e) All childcare request forms must be completed and returned to the Transportation Department Office by July 30th. We cannot guarantee that childcare requests received after July 30th will be approved. You must complete one (1) form per child. Requests must be renewed each subsequent year by submitting a new request by July 30th deadline.

NORTH ROSE - WOLCOTT CENTRAL SCHOOL DISTRICT

11631 SALTER-COLVIN ROAD

WOLCOTT, NEW YORK 14590

STUDENT RECORDS REQUEST

School Name: (Prior school) _____

School Address: _____

School City, State, Zip: _____

School Telephone: _____ School Fax: _____

PERMISSION IS HEREBY GIVEN TO NORTH ROSE-WOLCOTT SCHOOL DISTRICT
TO RECEIVE INFORMATION FOR REGISTRATION PURPOSES REGARDING:

Student Name: _____

DOB: _____

Grade Last Attended: _____

PLEASE SEND A COPY OF THE FOLLOWING:

- Birth Certificate
- Report Card
- Immunization and Health Reports
- OT, PT, Speech, Vision, Hearing, etc. Evaluations
- Log of Completed Math Investigations
- Discipline Records
- Transcript & Attendance Report
- IEP, 504 Plan or Declassification Notes
- Psychological/Psychiatric Evaluations
- Science Assessment Sheets (past 6 months)
- Achievement Test Scores
- IEP Goals Progress Reports
- Parental Consent for Special Education Services
- OT, PT, Speech Scripts

Karen Haak, Principal
North Rose-Wolcott Elementary School
10456 Salter Road
North Rose, NY 14516
Phone: 315-587-4005 Fax: 315-587-2432
Email: cbradford@nrwcs.org

Crystal Yarnes, Principal
Leavenworth Middle School
5937 New Hartford Street
Wolcott, NY 14590
Phone: 315-594-3130 Fax: 315-594-2471
Email: jsmith-bundy@nrwcs.org

Nicole Sinclair, Principal
North Rose-Wolcott High School
11631 Salter-Colvin Road
Wolcott, NY 14590
Phone: 315-594-3106 Fax: 315-594-1920
Email: lsheffield@nrwcs.org

NR-W CSE Office
10456 Salter Road
North Rose, NY 14516
Phone: 315-594-3114
Fax: 315-587-9925
Email: cpalmer@nrwcs.org (K-age 21)
Email: npickett@nrwcs.org (Preschool
and 504 Plan)

Signature of Parent/Guardian

Date



Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

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

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

Home Language Questionnaire (HLQ)

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

STUDENT NAME:		
<i>First</i>	<i>Middle</i>	<i>Last</i>
DATE OF BIRTH:		GENDER:
<i>Month</i>	<i>Day</i>	<i>Year</i>
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to</i>

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<i>specify</i>	_____
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

North Rose-Wolcott CSD 11631 Salter-Colvin Rd, Wolcott, NY 14590

District Name (Number) & School:

Address:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure
 *If yes, please explain: _____

How severe do you think these difficulties are? Minor Somewhat severe Very severe

10a. Has your child ever been **referred** for a special education evaluation in the past? No Yes* *Please complete 10b below

10b. ***If referred for an evaluation**, has your child ever **received** any special education services in the past?
 No Yes – Type of services received: _____

Age at which services received (Please check all that apply):
 Birth to 3 years (Early Intervention) 3 to 5 years (Special Education) 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? No Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? _____

Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
Date

Relationship to student: Parent Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: No Yes

**DATE OF INDIVIDUAL INTERVIEW: _____
 MO. DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:
 ADMINISTER NYSITELL
 ENGLISH PROFICIENT
 REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

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

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

**North Rose-Wolcott Central School District
Committee on Special Education
11631 Salter-Colvin Road
Wolcott, NY 14590 (315-594-3132)**

Medicaid Consent

Dear Parent/Guardian:

This is to ask your permission (consent) to bill your or 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 School District to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____ have received a written notification from the School District 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 School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district 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	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	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.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

***Please provide your child's Medicaid CIN# from their personal Medicaid card: _____**

(The CIN# is the Alphanumeric ID Number located above the sex and DOB on your child's Medicaid card.
It starts with 2 letters, followed by 5 numbers, and ends with 1 letter.)

NORTH ROSE - WOLCOTT CENTRAL SCHOOL DISTRICT
11631 SALTER-COLVIN ROAD WOLCOTT, NEW YORK 14590

HEALTH INFORMATION

Last Name	First Name	Date of Birth
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Child's Medical History

<u>Illness</u>	<u>Date</u>	<u>Illness</u>	<u>Date</u>
TB/Contact with TB		Lead poisoning	
Head Injury		Asthma	
Meningitis		Heart disease/murmur	
Chicken Pox		Diabetes	
Pneumonia		Kidney disease	
Recurrent sore throats or ear infections		Seizure disorder	
Other illness or disease		Bleeding disorder	

1. Does your child have any allergies (food, insects/bees, medications, trees, molds, etc.)? If so, please list:

2. Is your child presently taking any medications: If so, please list:

3. Have you ever suspected that your child may have poor eyesight? YES NO
 If so, has he/she ever been seen by an optometrist or eye specialist? YES NO
 Result of the examination and recommendations: _____

4. Have you ever suspected that your child may have a hearing problem? YES NO
 If so, has he/she been evaluated by a doctor: YES NO
 Result of the examination and recommendations: _____

5. Have you ever suspected that your child may have a speech or language problem?
 YES NO If so, has he/she had a speech or language evaluation: YES NO
 Result and recommendations: _____

6. Has your child had any other screenings or evaluations (psychological, educational, allergy testing, physical therapy, occupational therapy, etc.)? YES NO
 If so, what were the results? _____

7. Has your child had illnesses, injuries, or operations requiring hospitalizations?
 YES NO If so, when, where and for what reason? _____

8. Is there any condition that limits classroom or physical education activities: YES NO
 If so, please describe _____

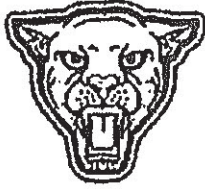
Student's Doctor _____

Student's Dentist _____

Name of preferred hospital _____

Date

Signature of Parent / Guardian



North Rose-Wolcott Central School District

10456 SALTER ROAD NORTH ROSE, NEW YORK 14516 PHONE (315) 594-3114 FAX (315) 587-9925

Exchange of Information Form

In New York State, occupational and physical therapists must have a doctor's prescription before treating students. Please fill out this form and return it to school. It gives us permission to speak to your child's doctor and get a prescription for occupational and/or physical therapy services. In addition, it is sometimes necessary for our counselors, psychologists, speech pathologists and nurses to speak with your child's doctor(s) and/or specialist(s).

I give the occupational and/or physical therapists, counselors, psychologists, speech therapists and nurses of the North Rose-Wolcott Central School District permission to exchange information concerning my child, _____, DOB _____, with his or her physician(s) and or specialist(s).

Doctor's name: _____

Address: _____

Phone number: _____ Fax number: _____

Doctor's name: _____

Address: _____

Phone number: _____ Fax number: _____

(Please include any other physicians/specialists on the reverse side, thank you!)

Parent or guardian signature

Date

**PLEASE RETURN THE COMPLETED FORM TO SCHOOL AS SOON AS POSSIBLE SO THAT
WE CAN BEGIN WORKING WITH YOUR CHILD.
THANK YOU!**

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

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

STUDENT INFORMATION

Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI _____ kg/m2

Percentile (Weight Status Category): <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$				
<input type="checkbox"/> System Review and Abnormal Findings Listed Below				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

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

2025-26 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the [“ACIP-Recommended Child and Adolescent Immunization Schedule.”](#) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³	Not applicable		1 dose	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
 - c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 9: 10 years; minimum age for grades 10, 11, and 12: 7 years)
 - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
 - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 12.
 - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
 - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
 - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
 - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
 - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
 - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
 - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
 - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
 - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
 - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 10: 10 years; minimum age for grades 11 and 12: 6 weeks)
 - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
 - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
 - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
 - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
 - d. If dose 1 was received at 15 months or older, only 1 dose is required.
 - e. Hib vaccine is not required for children 5 years or older.
 - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
 - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
 - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
 - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
 - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
 - e. PCV is not required for children 5 years or older.
 - f. [For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.](#)

For further information, contact:

**New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437**

**New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433**

Google Apps for Education User Expectations/Policy

What are Google Apps for Education?

Google Apps for Education is a set of free, customizable tools that provide opportunities for students and faculty to work more effectively in a collaborative environment. This comprehensive, cost-effective IT solution is entirely browser-based, making it easier for students to work from any Internet-accessible computer or mobile device, without having to purchase expensive software to communicate or do their homework.

Student accounts may include tools such as email, shared documents, websites and blogs. Students will use Google Apps for educational purposes and can be accessed from anywhere you have internet connection, allowing students to easily turn in assignments electronically and collaborate on projects with classmates and teachers.

Student Acceptable Use Policy

- In order to use Google's services, all students must abide by the Student Acceptable Use Policy (AUP). A copy of the AUP is available for your review on the school's website. As noted in the AUP, students should have no expectation of privacy with GAFE.
- When sharing a document, spreadsheet, presentation, or other file with other users, all users must be agreeable to receiving an invitation to collaborate and treated with respect.
- Google accounts are for school purposes only. Emphasis will be made that this account is not to be used for any social or entertainment purposes. It should only be used for school assignments. Email accounts are not to be used to create any social media accounts.

Email

Gmail is the email program that comes with GAFE. Email will be enabled for students in grades 3-12 with exceptions. Grades 3-8 cannot send or receive email outside the NRW Domain. Email will be enabled for grades 9-12 with the ability to send and receive outside the NRW Domain. With this, students will be able to communicate with staff and students within the North Rose Wolcott Central School District domain for educational purposes only.

Google Drive

Google Drive gives users cloud storage space for most file formats. Google drive can be accessed from any computer with an Internet connection. Google Drive includes:

- Google Documents - word processor similar to Microsoft Word
- Google Presentation - presentation tool similar to Microsoft PowerPoint
- Google Sheets - spreadsheet program similar to Microsoft Excel
- Google Forms- survey/data tool
- Google Drawing - simple graphic design program

Who will be using GAFE?

All students in the North Rose Wolcott Central School District will have access to GAFE. If you wish to not have your child have an email account, please fill out and return the attached form.

I confirm that I have read and understand the following:

If you **DO NOT** want your student to access Google Mail please complete, sign, and return this form to your child's school. If, at any time during the school year, you would like to rescind your decision and change your permission, you must let the school know in writing.

I DO NOT want my student to be allowed access to Google Mail.

Student Name: (Print)

Grade:

Parent/Guardian

Signature: Date:

Please return to your children(s) school with all other registration material.

AGREEMENT

I have read the North Rose Wolcott Central School District Technology Agreement and agree to abide by their provisions.

I understand that my use of the district's technology is not private and that the school district monitors the use of district technology, including but not limited to accessing browser logs, and any other history of use including on student-owned devices connected to district technology.

I consent to district interception of, or access to, all communications I send, receive or store using the district's technology resources, pursuant to state and federal law, even if the district's technology resources are accessed remotely.

Student Name (Print Neatly) _____

Signature of Student/Date _____

Graduation Year _____

Home Address _____

Home Phone Number _____

As a parent and/or guardian, I will talk with my students about the use of technology and the internet and have an ongoing dialogue regarding their experiences.

I recognize that appropriate use of technology is an important skill, and I play a significant role in my child's instructional experience in school and outside of school.

We will establish rules, openly discuss and monitor my child's use of technology to support their learning and to encourage positive relationships with peers.

Topics we will discuss are the appropriate use of technology, how we interact with peers and individuals that we know appropriately, and how we stay safe by not interacting with strangers.

Signature of Parent-Guardian/Date _____

Home Address _____

Home Phone _____

Email Address _____

PROCESS:

1. All new accounts are completed at the registrar's office.
2. The registrar's office will provide a copy of the request to the Technology Department
3. The Technology Department will be responsible for setting up a student account and communicating with the school he/she is registered at with account information.

PARENTS' BILL OF RIGHTS FOR DATA PRIVACY AND SECURITY

In accordance with Education Law Section 2-d, the North Rose- Wolcott Central School District hereby sets forth the following Parents' Bill of Rights for Data Privacy and Security, which is applicable to all students and their parents/legal guardians.

1. A student's personally identifiable information cannot be sold or released by the District or BOCES for any commercial or marketing purposes.
2. In accordance with FERPA, Section 2-d and Board Policy 7240 Student Records: Access and Challenge, parents have the right to inspect and review the complete contents of their child's education record, including any student data stored or maintained by the District or BOCES.
3. The District has the following safeguards in place to protect student data, including personally identifiable information stored or transferred by the District or BOCES.
 - a. All databases that have student information are protected by a secure password and login. These logins are monitored and kept up to date.
 - b. Student information is only accessible by those that are deemed warranted of having the information.
4. The New York State Education Department collects a number of student data elements for authorized uses. A complete list of all student data elements collected by the State is available for public review from the State Education Department.
5. Parents have the right to submit complaints about possible breaches of student data or teacher or principal APPR data. Any such complaint must be submitted, in writing, to:

Data Protection Officer
11631 Salter-Colvin Rd.
Wolcott, NY 14590

Supplemental Information Regarding Third-Party Contractors

In the course of complying with its obligations under the law and providing educational services to District residents, the District has entered into agreements with certain third-party contractors. Pursuant to such agreements, third-party contractors may have access to "student data" and/or "teacher or principal data," as those terms are defined by law.

Each contract the District enters into with a third-party contractor, where the third-party contractor receives student data or teacher or principal data, will include the following information:

- 1) The exclusive purposes for which the student data or teacher or principal data will be used.
- 2) How the third-party contractor will ensure that the subcontractors, persons or entities that the third-party contractor will share the student data or teacher or principal data with, if any, will abide by data protection and security requirements.
- 3) When the agreement expires and what happens to the student data or teacher or principal data upon expiration of the agreement.
- 4) If and how a parent, student, eligible student, teacher or principal may challenge the accuracy of the student data or teacher or principal data that is collected.
- 5) Where the student data or teacher or principal data will be stored (described in such a manner as to protect data security), and the security protections taken to ensure such data will be protected, including whether such data will be encrypted.



NORTH ROSE - WOLCOTT CENTRAL SCHOOL DISTRICT

Academics 🐾 Commitment 🐾 Excellence

P.O. BOX 340 🐾 WOLCOTT, NEW YORK 14590 🐾 P. 315.594.3141 🐾 F. 315.594.2352

Michael L. Pullen
Superintendent of Schools

Megan C. Paliotti
Assistant Superintendent
for Instruction and School Improvement

DISTRICT CHILD FIND PROCEDURE

The North Rose Wolcott Central School District is committed to meeting the needs of students with different learning styles. Referrals to the Committee on Special Education (CSE) can only be made by parents, and requests for referral can be made by teachers, providers, or physicians. The CSE is appointed by the Board of Education to conduct comprehensive evaluations for students who have been referred to the CSE. If the information gathered during the evaluation supports classification according to New York State Education Law, the CSE will then develop an Individualized Educational Program (IEP) to address the unique learning needs of the student. The Board of Education has also appointed CSE subcommittees to facilitate the meeting process. It is important to note that not all students who are experiencing school difficulties are eligible for special education services.

Once a student is identified with a documented disability by mandated criteria, our special education services provide for the individual needs of the student including academic, social, physical, and management needs. These are provided with the goal of serving the student in the least restrictive environment. In the North Rose Wolcott School District, the first consideration is education of students with disabilities in general education in their home school. Sometimes, student needs may surpass what is available in district and alternative programs need to be considered to best meet student needs (e.g. BOCES programs, private programs).

Preschool age children may also be eligible for special education services, through a similar process overseen by the Committee on Preschool Special Education (CPSE). Educational programs and services for preschool children with disabilities from the ages of three to five are the responsibility of the school district in which the child resides in accordance with New York State Education Law. There is also birth to age two services provided by the county of residence.

The North Rose Wolcott Central School District, in compliance with the Regulations of the Commissioner of Education and Education Law, is required to locate all children with disabilities within its jurisdiction under the age of twenty-one. Children of preschool age and children in all public and private agencies and institutions must be identified, located and evaluated in the district in which they reside. If you suspect your child(ren) ages 3-21 of having a disability and are not receiving special education services, please contact the Director of Special Education at 594-3133.

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>

Chelsea Eaton

Director of Special Education and Pupil Personnel Services

Ph.: 315-594-3133

Fax: 315-587-9925

Nicole Pickett

CPSE & Section 504 Secretary

315-594-3132

Chelsey Palmer

CSE Secretary (K - age 21)

315-594-3114

North Rose-Wolcott Central School District



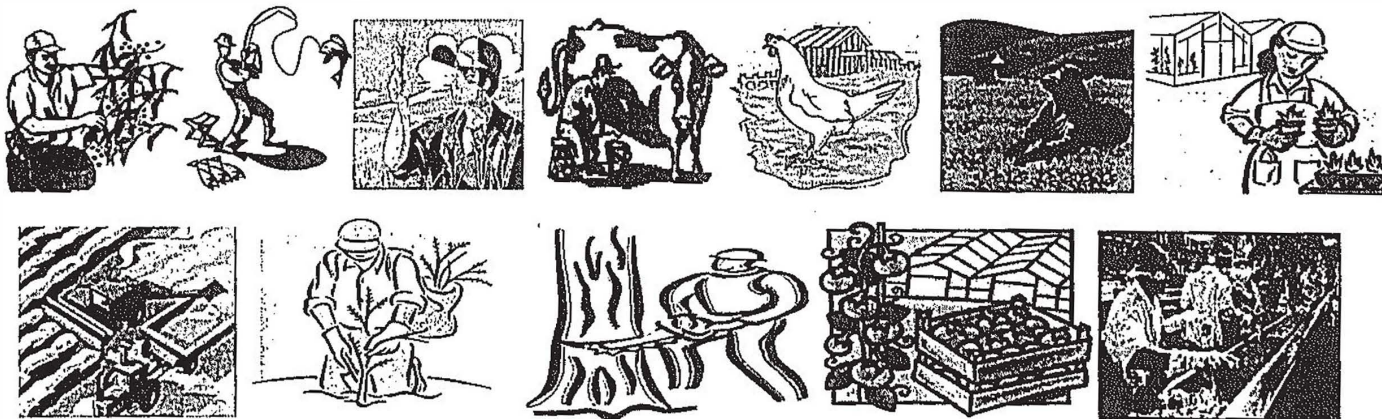
IDENTIFICATION & RECRUITMENT PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

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



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

Parent/Guardian Name: _____

Home address: _____

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

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

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