Glens Falls City Schools

Welcome to Glens Falls City School District

The mission of the Glens Falls City School District is to provide a safe, positive and stimulating environment – one that fosters self-growth, a passion for continuous learning, confidence and the ability to succeed in a changing world.

We promote excellence through high expectations and evolving standards for students, staff, parents and community. The challenge is to reach one's personal best while respecting each person's individuality.

We make it our responsibility to be accountable for the implementation of this mission and to model behaviors that are influential to the character as well as the mind.

All of the following pages should be completed when submitting registration

- ◯ **Student Registration 108 Form**
- ◯ **Housing Questionnaire**
- ◯ **Home Language Form**
- ◯ **Proof of Residency**
- ◯ **Medicaid Consent Form** (We ask all registrants to sign this form regardless)
- ◯ **Release of School Records and Information**
- ◯ **Health Registration Form**
- ◯ **Authorization for Release of Confidential Information**
- ◯ **Social History Form**
- ◯ **Acceptable Use Policy** (Does not need to be returned)
- ◯ **Sports Questionnaire** (Grades 7-12)
- ◯ **Custody Papers or Affidavit** (If applicable)
- ◯ **Birth Certificate**
- ◯ **Immunization/Physical Form**

GLENS FALLS CITY SCHOOL DISTRICT
Glens Falls, New York 12801

Student's Last Name _____ **Middle**_____ **First**_____

Grade:_____ **Sex:** _____ **Date of Birth:**_____

Place of Birth (City, State, Country)_____

(If place of birth is outside of the U.S please list date entered U.S) _____

Please answer questions (1) and (2). Please read them before you respond.
For question (1) check the box that best describes your child. Check only ONE box.

1. **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

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

Student's address:_____

Phone Number: (_____) _____-_____ **Is this number listed? Yes No**

Father's Name: _____

Address:_____

Does the father reside with student? Yes / No

Father's Home phone: (_____) _____-_____

Cell # (_____) _____-_____

Father's place of employment:_____

Work #(_____) _____-_____ **Email Address:**_____

Mother's Name: _____

Address:_____

Does the mother reside with student? Yes / No

Mother's Home phone: (_____) _____-_____

Cell phone # (_____) _____-_____

Mother's place of employment:_____

Work #(_____) _____-_____ **Email Address:**_____

Other Adult with Family: _____

What is this person's relationship to child?_____

Cell phone # (_____) _____-_____

Place of employment _____

Work # (_____) _____-_____

Emergency Contact: _____

(If parents are not available in an emergency call. This person should be in the local area)

Address: _____

Home phone: _____ **Cell:** _____

Work:_____

Relationship to Child:_____

Is there anyone to whom the student cannot be released due to court order/order of protection? Yes / No

*If yes, please provide a copy of the order(s)

Did the Student ever attend a Glens Falls School? Yes/No

If yes, List School _____

OTHER INFORMATION: (Has your child ever received? (check any that apply)

AIS Reading:_____ **AIS Math:**_____ **Special Education (IEP):**_____ **Physical Therapy:**_____

Occupational Therapy:_____ **Adaptive P.E.:**_____ **English as a Second Language:**_____

Speech:_____ **504 Plan:**_____ **Gifted Program:**_____ **Musical Instrument:**_____

Counseling Services: _____ **Social Work:**_____

Was Student ever retained? Yes/No

(If Yes) Grade retained: _____ **School:**_____

Please Note: Glens Falls CSD may occasionally use student photographs, video recordings or work on the district website, social media and/or in district and community publications. Any parent or guardian who does not wish to have his/her child(s) picture or work used for these purposes must notify the building principal in writing.

Signature of Parent/Guardian: _____

Date: _____

Housing Questionnaire - Glens Falls City School District

Your answers will help determine if the student meets eligibility requirements for services under the McKinneyVento Act.

Student _____ Parent/Guardian _____

School _____ Phone _____

Age _____ Grade _____ D.O.B. _____

Current Address _____

City _____ Zip Code _____

Previous Address: _____

Previous School (If applicable): _____

Is this address Temporary **or** Permanent? (circle one)

Please choose which of the following situations the student currently resides in (you can choose more than one):

____ House or apartment with parent or guardian

____ Motel, car, or campsite

____ Shelter or other temporary housing

____ With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

____ Provide care for a family member

____ Living with boyfriend/girlfriend/partner

____ Parent/Guardian is deployed

____ Loss of housing due to:

- ____ Economic situation
- ____ Temporarily waiting for house or apartment
- ____ Other (Please explain)

Is DSS coordinating temporary housing for you? Yes No

Are you a student living apart from your parents or guardians? Yes No

Housing and Educational Rights Students without fixed, regular, and adequate nighttime residences have the following rights:
1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations; 2) Transportation to the school of origin for the regular school day; 3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students. Any questions about these rights can be directed to the local McKinney-Vento liaison at 518-792-1212.
By signing below, I acknowledge that I have received and understand the above rights.

_____

Signature of Parent/Guardian/UHY Youth Date

_____

Signature of McKinney-Vento Liaison/ Date

Updated 1/2024 Source: NCHE Local Liaison Toolkit, 2020

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:

INSTRUCTIONS FOR COMPLETING THE HOUSING QUESTIONNAIRE

Purpose of the Housing Questionnaire

All Local Education Agencies (LEAs) are required to identify students experiencing homelessness. LEAs include school districts, charter schools and BOCES. Additionally, all LEAs that receive Title I funds must ask enrolling students about their housing status. The New York State Education Department (NYSED) encourages all LEAs regardless of whether they receive Title I funds to do the same. To collect this information, LEAs may:

1. Use the Housing Questionnaire attached here,
2. Update/modify the Model Enrollment Form – Housing Questionnaire to address the needs of the LEA, or
3. Incorporate the housing status question from the Model Enrollment Form - Residency Questionnaire into the LEA's Enrollment Form or other documents already used by the LEA during the enrollment process.

If an LEA elects the third option and incorporates the housing status question into the LEA's Enrollment Form, the LEA should take steps to ensure that a student's housing status does not become a part of the student's permanent record, because of the sensitive nature of this information. Please see the section titled "Confidentiality" (below) for information about how and when housing information may be shared within the LEA.

Who should fill out the Housing Questionnaire?

A Housing Questionnaire should be filled out for all students enrolling in school and for all students who have a change of address in grades preschool-12. "Preschool" includes any LEA administered or funded preschool program, such as a pre-k or Head Start program administered by an LEA. The Housing Questionnaire should be completed by the student's parent, person in parental relation, or in the case of an unaccompanied youth, by the student directly.

Confidentiality

Student housing information should be kept confidential to the maximum extent possible. This information should only be shared with LEA/school staff members who need information about housing status to ensure that the student's educational needs are met. To this end, LEAs may share a student's Housing Questionnaire with LEA personnel such as:

1. the LEA liaison,
2. the registrar,
3. the student's teachers, and/or guidance counselor, and
4. the LEA staff member responsible for reporting data to SED

However, this information should only be shared with the above staff members to the extent that it will enable them to better meet the educational needs of the student in question and to fulfill reporting requirements mandated by SED.

Other than the above uses, housing information **should be kept confidential** and **should not be shared** with other LEA/school personnel due to its sensitive nature and the stigma attached to being labeled homeless. LEAs are also encouraged to seek out ways of preventing Housing Questionnaires and housing information from becoming a part of a student's permanent record.

Discussing the Housing Questionnaire with Students and Families

In reviewing the Housing Questionnaire with parents, persons in parental relation, and unaccompanied youth, LEAs should emphasize that the purpose of gathering the information is to ensure that students in temporary housing arrangements are provided with the rights and services to which they are entitled under the McKinney-Vento Act. These rights and services include:

1. The right to stay in the same school the student had been attending before losing his/her housing or the last school attended (both known as the school of origin),
2. The right to immediate enrollment for students who decide to transfer schools, even if the student does not have all of the documents normally for enrollment,
3. Transportation services if the student continues to attend the school of origin,
4. Categorical eligibility for Title I services if offered in the LEA,
5. Categorical eligibility for free meals if offered in the LEA, and
6. Access to services provided with McKinney-Vento funds if available in the LEA.

The LEA should also ensure that the parent, person in parental relation, unaccompanied youth is aware that the student's housing status will kept confidential and will only be shared with those LEA staff who are responsible for providing services to the student and those responsible for keeping track of how many students are identified as living in temporary housing in the LEA.

LEAs are advised to explain to parents that if a parent claims that her/her child is living in temporary housing, and the LEA wishes to conduct an investigation to verify this information, the LEA may conduct a home visit. However LEAs **cannot contact a landlord or building superintendent** to verify a student's housing status without prior parental consent. Contacting a landlord or building superintendent without the parent's express prior written permission is a violation of FERPA, a federal law.

If the Parent, Person in Parental Relation, or Unaccompanied Youth Declines to Fill Out the Housing Questionnaire

If the parent, person in parental relation, or unaccompanied youth declines to complete the Housing Questionnaire, the LEA should note on the form that the parent, person in parental relation, or unaccompanied youth declined to provide the information requested.

Completing the Form

If a parent, person in parental relation, or unaccompanied youth enrolling in school indicates that a student is living in one of the five temporary housing arrangements, the school may not require proof to verify where the student is living before enrolling the student. The five temporary housing arrangements are listed below:

1. In a shelter,
2. With another family or other person (sometimes referred to as "doubled-up"),
3. In a hotel/motel,
4. In a car, park, bus, train, or campsite, or
5. Other temporary living situation.

After the student is enrolled and attending classes, the school or LEA is permitted to verify the student's housing arrangements. However, the student must first be enrolled in school. Again, LEAs **cannot not contact a landlord or building superintendent** to verify a student's housing status. (See above for more information.)

Definitions of Temporary Housing Arrangements

"With another family or other person" (also referred to as "doubled-up")"

LEAs should be aware that students who are sharing the housing of others are eligible for services under the McKinney-Vento Act and State law, if sharing housing is due to loss of housing, economic hardship, or a similar reason.

"Other temporary living situation"

In addition to the four examples of temporary housing, students who lack a "fixed, adequate, and regular" nighttime residence are also covered as homeless under the McKinney-Vento Act and State law. This may include unaccompanied youth who have fled their homes or were forced to leave their homes and who do not otherwise meet the definition of "doubled-up."

"In permanent housing"

Permanent housing means that the student's living arrangements are "fixed, regular, and adequate."

Next Steps for LEAs with Students Living in Temporary Housing Arrangements

f the parent, person in parental relation, or unaccompanied youth indicates that a student is living in temporary housing, the .EA must complete a Designation Form. If the LEA believes additional information is needed before reaching a final decision on he student's eligibility under McKinney-Vento, enrollment should not be delayed and a Designation Form should still be filled ut. For more information about determining eligibility see the National Center on Homeless Education's Determining Eligibility rief, available at: http://nche.ed.gov/downloads/briefs/det_elig.pdf.

a student who is identified as homeless was last permanently housed in a different school district, the district of ttendance/local district will be eligible for tuition reimbursement from SED for the cost of educating the student. School istricts should complete a STAC-202 form if eligible for tuition reimbursement. For more information about STAC-202 forms ontact the STAC Office at 518-474-7116 or NYS-TEACHS at 800-388-2014.

Registration Requirements:

*Only children who are at least 5 years old as of December 1st of the year of enrollment, under 21 and do not possess a high school diploma may enroll. In addition, children seeking to enroll must be residents of the district.

**UPK students must be 4 years old as of December 1st of the year of enrollment.

- **Proof of residence** which includes the name and address of the parent(s) or guardian(s) and is dated within 30 days (recent date).
- **Proof of Age** - Original documentation of birth, in the form of an original, state-issued birth certificate, baptismal certificate or passport
- **Immunization Record** signed by a physician or clinic staff
- **Custody Papers or signed and notarized Affidavit** if applicable.

Proof of Residency Requirements:

Proof of residence which includes the name and address of the parent(s) or guardian(s) and is dated within 30 days (recent date). Examples of proof of address include the following:

Driver's License: with current physical address of residence, will also require 1 additional document. (see list below)

And/Or (One of the following):

- **Utility Bill** (Gas, Electric, Water, Waste, Cable, Wi-Fi, Landline (non-cell))
- **STAR Exemption**
- **Lease Agreement**
- **Mortgage Statement**
- **Assistance Letter**

Items NOT Accepted:

- Bank account statements
- Rent receipts
- General Mail
- Tax bill
- Payroll checks
- Insurance cards

Glens Falls City School District
Office of Special Education
10 Sanford Street
Glens Falls, NY 12801
Telephone (518) –793-7395 Fax (518) 793-7399

10-25-22

Dear Parent:

Enclosed please find the Medicaid Consent Form that is included in your initial registration packet for the district. Please sign and return even if you are not receiving Medicaid at this time. This will not impact your insurance in any way and will not reduce your Medicaid benefits. This consent allows the district to submit for related services provided in the school environment should your child become Medicaid eligible.

If you have any questions at all, please feel free to call me. I am only in the office two days a week but will respond when I am here. You may also email me at: bsealy@gfsd.org.

Sincerely,

Barbara Sealy
Medicaid and STAC Specialist

Office of Special Education
Committee on Special Education
Sanford Street Elementary School
10 Sanford Street
Glens Falls, NY 12801 ((518) 793-7395)

Medicaid Consent

Date:
RE: Student Name _____
DOB:
Client Identification Number (CIN):

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 program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

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

I, _____ as the parent/guardian of _____, have received a written notification from the school district/county that explains my federal 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/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or 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 and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

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

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

Student's CIN, if known: _____

___ I do not give consent to bill the Medicaid Insurance Program for special education and related services that are on my child's individualized education program (IEP). Regardless of my decision to deny consent, all required services in my child's IEP will be provided at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

RELEASE OF INFORMATION FROM SCHOOL RECORDS

I do hereby authorize: GLENS FALLS CITY SCHOOL DISTRICT

15 QUADE STREET GLENS FALLS, NY 12801

To RELEASE or OBTAIN all school records and information including: State Assessments, leaving grades when applicable, health and immunization records, and psychological testing* and IEP's* or 504 Plan* where applicable. (*See address below)

Student Name: _____

From: **(Name and Address of Last School the Student Attended)**

_____

_____

_____

Signed: _____ **(Parent or Guardian)**

Signed: _____ **(Student if 18 or over)**

Please return information and records to:

◯ Big Cross Elementary Main Office 15 Big Cross Street Glens Falls, NY 12801

Fax: (518) 792-2668/email: bharris@gfsd.org

◯ Jackson Heights Elementary Main Office 24 Jackson Avenue Glens Falls, NY 12801

Fax: (518) 798-6501/ email: sfrandsen@gfsd.org

◯ Kensington Road Main Office 43 Kensington Road Glens Falls, NY 12801

Fax: (518) 793-5404/ email: awhitman@gfsd.org

◯ Glens Falls Middle School Guidance Office 20 Quade Street Glens Falls, NY 12801

Fax: (518) 793-4888/ email: **kholser@gfsd.org (Preferred Method)**

◯ Glens Falls Senior High Guidance Office10 Quade Street Glen Falls, NY 12801

Fax: (518) 792-5836/ email: **tchandler@gfsd.org (Preferred Method)**

◯ * Special Education Office 10 Sanford Street Glens Falls NY 12801

Fax: (518) 793-7399/email: zstevens@gfsd.org

Authorization for Release of Confidential Information

I hereby consent to and authorize Glens Falls City School District to obtain from and/or release to:

_____
Name of Child's Pediatrician

_____
Address/City/State/Telephone/Fax

The following information pertaining to:

_____
Child's Name

_____
Child's DOB

The information to be disclosed is:
-Educational Evaluations/Reports
-Medical Evaluations/Reports
-Psychological Evaluations/Reports
-Medical history and physical examination
-Diagnosis, brief description of progress and prognosis
-Immunization Records

This information is needed for the following purposes:
-To provide ongoing treatment/continuing care
-To coordinate treatment efforts with parent/guardian
-To coordinate educational planning
-To coordinate services with authorized school officials and/or community service providers

I understand that I have the right to revoke this authorization at any time by submitting a request in writing. The revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one-time release or a periodic release of information. I understand that disclosure of this information is voluntary. I understand that I have a right to receive a copy of this authorization. The duration of this authorization is for no longer than one (1) year unless I specify a date, event or condition upon which it will expire sooner. Rerelease of this information without written consent is prohibited.

_____
Parent/Guardian Signature

_____
Date

HUDSON HEADWATERS
HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number	
Street Address	City	State	Zip Code

A) I hereby authorize records FROM:

Name: Hudson Headwaters Health Network

Address: 9 Carey Rd

City/State/Zip: Queensbury, NY 12804

Phone: (518) 761-0300 Fax: (518) 745-1378

B) To be released TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

C) Information disclosed: *(please select one)*

☒ Medical information ☐ Dental information

☐ Entire record set

☐ Date range: _____ to _____

☒ Other: School Notes and Physical Forms

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

_____ Alcohol/Drug treatment

_____ HIV/AIDS-related information

_____ Mental health treatment

E) Purpose of requested information: *(please select one)*

☒ At the request of the individual ☐ Transfer of care *(select reason)*

☐ Legal purposes ☐ Patient experience ☐ Other: _____

☐ Coordination of care ☐ Patient relocation

F) Delivery method: *(please select one)*

☐ US mail (Paper) ☐ US mail (CD) ☐ Pick up at: _____

☐ Encrypted email: _____ ☒ Fax to: _____

G) Authorization Expiration: Unless previously revoked by me in writing, this authorization will expire on the following date or event: _____ *Please note: If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:	I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **HIV RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.

_____ Signature of Patient or Representative Authorized by Law

_____ Print Name

_____ Date

Glens Falls City School District
Glens Falls, NY

NEW ENTRANT PHYSICAL AND IMMUNIZATION REQUIREMENTS

New York State Public Health law, section 2164 mandates that schools not permit a child to be admitted unless the parent provides the school with a certificate of immunization or proof from a physician that the child is in the process of receiving the required immunizations.

All immunizations must be documented by your physician or local health department where the child received the immunizations, or must be from an official copy of the immunization record from the child's previous school. All immunizations must specify the exact date each immunization was administered. **Your child will not be permitted to attend school without the necessary verification of immunizations.**
The required immunizations can be obtained from your family physician or you may call Warren County Public Health at 518-761-6415.

REQUIRED IMMUNIZATIONS:

For Elementary School entrance:

- **5** doses of **diphtheria, tetanus and acellular pertussis** (DTaP, Pentacel, Pediarix).
- **4** doses of **poliovirus** vaccine (IPV).
- **3** doses of **hepatitis B** vaccine
- **2** doses of **MMR (Measles, Mumps, Rubella)** vaccine, the first administered **after** 12 months of age and the second prior to kindergarten.
- **2** doses of **varicella** vaccine

For Middle and High School entrance:
All of the above immunizations with the following additional requirements:

1 dose **Tdap** - 6th grade requirement (student must be 11 years of age or older)
1 dose **Meningococcal** - 7th grade requirement
2nd dose **Meningococcal** - 12th grade requirement **(Menevo, MenQuadfi, Menactra only)**

PHYSICAL REQUIREMENT:

A physical or health examination performed by an MD, NP or PA in NY state within the 12 (twelve) months prior to school entry must be provided to the school. If no physical examination is provided after 30 (thirty) days, a physical examination will be performed by the school physician.

If you have further questions or concerns about immunizations or physicals, please feel free to contact the nurse at which school your child will be attending.

GF School Nurses:

Beth Clark RN: Kensington Road
Katasha Barry RN: Big Cross
Missy Higley: RN: Jackson Heights
Olivia Dunbar RN: St Mary's/St Alphonsus
Andrea Romeo RN: Middle School
Tracy Webster RN: High School

Glens Falls City School District

Glens Falls, NY 12801

HEALTH REGISTRATION FORM

Student's Name:_____ DOB:_____

If you check yes to any of the following, please provide details below. Include date(s), treatment prescribed, physician's name, and current status of problem.

	YES	NO		YES	NO
ADD/ADHD	____	____	Head Injury/Concussion	____	____
Bee Sting Allergy	____	____	Heart Problem/Murmur	____	____
Asthma	____	____	Fractures/Dislocations	____	____
Arthritis	____	____	Orthodontic Appliance	____	____
Ear Tubes	____	____	Surgery	____	____
Bladder/Kidney Issues	____	____	Migraines	____	____
Convulsions/Seizures	____	____	Glasses/Contacts	____	____
Diabetes/Hypoglycemia	____	____	Other_____		

_____

_____

_____

_____

_____

Family Physician or Pediatrician:_____

1. Medical information details (Included significant birth history, disabilities, speech difficulties, etc.):_____

_____

Is your child presently taking medication?_____Yes ____No

If yes: what medication (s) and for what reason (s)?_____

_____

Is the medication administered during the school day? _____Yes _____No

2. Does your child have allergies?

FOOD:_____

MEDICATION:_____

ENVIRONMENTAL:_____

3. Has your child been evaluated for or received any of the following services: Speech, OT, PT, Counseling? If so, please explain:

_____

4. Has your child ever seen a dentist? ____Yes ____No

If so, for what reason: _____

5. Should your child be restricted from participating in school gym or sports? ____Yes ____No

If yes, please provide written recommendations from your child's physician.

6. Additional Comments: _____

_____

_____

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

SOCIAL HISTORY FORM

Child's Name:_____ Age:_____ DOB: ___/___/___

Child's Preferred Name:_____Gender ___Male___Female

Ethnicity/Race:_____ Language(s) Spoken:_____

School Attending:_____ Child's Current Grade in School:_____

Current Address:

Street:_____ City/State:_____ Zip:_____

Please list the names, gender, ages, and level of education (i.e. high school, college, etc.) of all family members currently residing in your household and their relationship to your child (feel free to use the back.)

Name	Gender	Age	Relationship to Child	Level of Education	Living with Child
					__Y __N
					__Y __N
					__Y __N
					__Y __N
					__Y __N
					__Y __N

Please list any other information that would be important for us to know about your family:

_____

ADOPTION

Is your child adopted? ___Yes ___No If yes, at what age was your child adopted?_____

_____Domestic _____International (Country:_____)

Does your child know he/she is adopted? ____Yes ____No If yes, what does your child know about his/her adoption? _____

Does your child have any contact with his/her birth parent(s)? ___Yes ___No

If yes, please describe the nature and extent of the contact:_____

_____

Have any of the following changes occurred in your child's life? (please check all that apply)

__Parental separation/divorce __Remarriage/new partners __Parent incarcerated

__Death/ loss of a family member __Loss of/ new job for parent __Birth/Adoption

__Serious illness (child/family member) __Traumatic experience __Accident

__Exposure to **and/or** experience abuse **and/or** neglect (please specify the type(s) of abuse):

__Sexual abuse, neglect __Physical abuse, neglect __Emotional abuse, neglect

Please describe the nature of the change and how it has impacted your child's development and/or behavior:

_____

_____

COMMUNITY SUPPORTS

Is your child currently receiving counseling or psychiatric services? ___Yes ___No If yes, please list:

Name of provider:_____ Phone #:_____

Do you have any concerns about your child's safety? ___Yes ___No If yes, please explain:_____

_____

Please describe any other concerns you may have about your child's psychological health and well being that would be important for us to know:

_____

_____

Does your child attend school on a daily basis? ___Yes ___No If no, please describe your child's current attendance (i.e. modified day, suspended, expelled, dropped out, GED program, etc.)

_____

On average, how many **days per month** is our child absent from school?_____

For what reason(s)?_____

In general, what is your child's attitude toward going to school and receiving an education?

_____

Has there been a change in your child's attitude toward attending school? ___Yes ___No

If yes, please describe when and what change(s) you observed:_____

_____

Has your child ever repeated a grade: ___Yes ___No If yes, what grade(s)_____

Is your child involved in any extracurricular activities at school or in the community? ___Yes ___No
If yes, what activities_____

_____

Does your child have a history of disciplinary or behavioral issues at school? ___Yes ___No
If yes, please describe the behaviors and what steps have been taken to address these behaviors:

_____

_____

Has there been involvement with outside law enforcement or probation for school-related problems (i.e. PINS)? ___Yes ___No If yes, please explain:_____

_____

Does your child have any of the following?
Individualized education plan (IEP) or a 504 plan? ___Yes ___No

Is there any other information that would be important for us to know to meet the educational and personal needs of your child?

_____

_____

_____

Name of person completing this form:_____

Relationship to child:_____ **Date:**_____

Student Acceptable Use Policy:
Computer, Network and Google Apps

Glens Falls City School District encourages the use of Internet connected computers and Google Apps for Education as effective and efficient ways to foster communication among students and teachers, develop collaboration skills, and develop 21st century technology skills. The District webpage and Google Apps for Education provide several services that allow students to collaborate on projects, correspond through a centralized email system, and maintain a web-based document store. The primary function of the Glens Falls City School District IT infrastructure is to support student learning through the effective and responsible use of Internet connected devices.

At present, student Google Apps for Education accounts have access to the following applications:

- Email (Grades 7-12)
- Documents
- Spreadsheets
- Presentations

School Responsibility

The District network account and Google Apps account assigned to your child were created by the District and assigned to your child to provide local and web-based connectivity to support electronic communication, plus a suite of tools allowing for the creation, editing, storing, and collaboration of documents and presentations. Concerning Google Apps, no personal information was collected by Google in creating these accounts. The school controls the Google services to which students have access.

In an effort to provide a safe experience for our students to grow and learn with web-based tools, student Google Apps accounts are limited to the gfsd.org domain. Even though Google Apps is a web-based suite of tools, students can not send to, or receive mail from accounts outside of the gfsd.org domain. In regard to document publishing and collaboration, any documents or presentations created using Google Apps cannot be published to the public web or shared with individuals outside of the gfsd.org domain.

Student Responsibility

By accessing Glens Falls City Schools network and its resources you are agreeing to the following:

1. I understand that the use of the District network, computers and Google Apps is a privilege, not a right, and that the system administrator may suspend my account at any time deemed necessary. Inappropriate use may result in a suspension of privileges and/or other disciplinary measures.
2. I understand that even if I am outside of school using District managed resources including Google Apps and the District website, I am still responsible for any and all actions I take.
3. I will not use Google Apps to transmit or post any harassing, obscene, discriminatory or offensive material. All material posted will be in keeping with school assignments.
4. I will not use Google Apps for personal email or social networking.
5. I will be polite and respectful of other students and users.
6. I will respect others' privacy and security when using all Web 2.0 resources.
7. I will accept personal responsibility for reporting any misuse of the web-based resources to school staff.

8. The District reserves the right to access student accounts, including current and archival files, including email, when there is reasonable suspicion that unacceptable use has occurred.
9. I will not use any District web-based resources to post any web pages for commercial activities, product advertisement, or political advocacy.
10. I will use the collaboration tools for the sole purpose of appropriate classroom discussion.
11. I will not share my District login credentials with other students and am responsible for all email and postings sent through my account.
12. I will not harm or destroy data of another user or student.
13. Glens Falls City School District scans and archives all inbound and outbound email, plus attachments. Using email for the spreading of viruses, profanity, offensive language, racist and/or sexual comments, virus hoaxes, lewd or obscene images, or chain mail will not be tolerated.
14. I understand the District reserves all rights to all information on the District's electronic environment and will remove any material which the District, at its sole discretion, believes may be unlawful, obscene, pornographic, abusive, or otherwise objectionable.
15. I understand and will abide by the generally accepted rules of network etiquette. These rules include (but are not limited to) the following:
    a. Being Polite: Never sending or encouraging others to send abusive messages.
    b. Using Appropriate Language: I understand that I am a representative of our school and District on the Internet and will use polite and appropriate language.
    c. Privacy: I will not reveal my home address or personal phone number or the addresses and phone numbers of other students. While using Internet services through Google Apps, I will not reveal my email address or the e-mail address of others.

Parent/Guardian Responsibility

I understand that although internet usage through student chromebooks outside of school is filtered and monitored, supervision of internet use at home is my responsibility. I will discuss our family rules and expectations for using web-based tools, including Google Apps Education. I will report any evidence of cyber bullying or other inappropriate use to the appropriate school official.

Glens Falls City School District
District Office ~ 15 Quade Street ~ Glens Falls, New York 12801~ (518) 792-1212 ~ Fax: (518) 792-1538

Dr. Krislynn Dengler
Superintendent

Anthony Cammarata
Assistant Superintendent for Business

Amanda Simmes
Assistant Superintendent for Curriculum & Instruction

AFFIDAVIT - DESIGNATING GLENS FALLS AS DISTRICT OF RESIDENCE

Student: **First Name:** _____ **Last Name:** _____

Date of Birth: ____/____/____ ☐**Male** ☐**Female** **Grade:** _____

Birth Mother: **First Name:** _____ **Last Name:** _____

Address: _____ **Cell Phone:** _____

Birth Father: **First Name:** _____ **Last Name:** _____

Address: _____ **Cell Phone:** _____

_____(Mother) and _____(Father) being duly sworn, depose and say:

1. We are the biological parents/guardians of _____ (Student's Name)

2. We state as follows: (choose either A or B)

   A. ____Pursuant to the attached signed **court document,** custody of _____ (Student's Name) is as follows:

      Joint Legal Custody to: _____

      Primary Physical Custody to: _____

   B. ____There are no custody court documents.

3. We agree to designate _____Mother's _____Father's (check one) residence located at _____ within the Glens Falls City School District, as _____ (Student's Name) residence for purposes of school attendance.

This affidavit is made for the purpose of requesting the Glens Falls City School District to admit _____(Student's Name) as a resident student on a tuition-free basis. We agree to notify the Glens Falls City School District in writing if at any time during the above child's attendance there is any change in the facts set forth above. We understand that signing this statement is a representation that the information provided is correct and true and made under penalty of perjury.

Birth Mother's Signature: _____

Sworn to before me this ____ day of _____, 202_

_____
Notary Public

Birth Father's Signature: _____

Sworn to before me this _____ day of _____,202_

_____
Notary Public