HORNELL CITY SCHOOL DISTRICT

Central Registrar's Office
134 Seneca Street • Hornell • New York • 14843
phone (607)324-1303 • fax (607)324-1346

Enter Date: School Name: Student ID#:

STUDENT REGISTRATION FORM

Student Name: ______________________________ **Grade Entering:** ________ **Gender:** ☐ Male ☐ Female

Legal Last Name *First* *MI*

Street Address: ______________________________

Street Name *Apt. #* *City* *State* *Zip*

Mailing Address: ______________________________

Street Name *Apt. #* *City* *State* *Zip*

Home Phone: ______________ **Unlisted:** ☐ (check if yes)

Birth Date: ______________ **Birth Place:** ______________

Month/Day/Year *City & State (or Country)*

Last School Attended: ______________________________

Name, Mailing Address and Telephone Number

Attended Hornell Previously? School: ______________

Is the Student a Citizen of the United States? ☐ Yes ☐ No

Race - Select one or more

☐ White (W)
☐ Asian (A)
☐ Black (B)
☐ Indian/Alaskan Native American (I)
☐ Native Hawaiian/Other Pacific Islander (P)

Hispanic/Latino Origin: ☐ Yes ☐ No

STUDENT EDUCATIONAL SERVICES

Does your child currently have an IEP? ______Yes ______No

Does your child currently have a 504 Plan? ______Yes ______No

Has your child ever repeated a grade in school? Grade:______ ______Yes ______No

Check any services listed below that your child has received in the past school year:

_____ Remedial Math
_____ Remedial Reading
_____ Speech
_____ ESOL (English as a Second Language)
_____ Occupational Therapy
_____ Physical Therapy
_____ School Counseling
_____ Counseling from an Outside Agency

PARENT/GUARDIAN INFORMATION

Student Lives with: (Circle One) Both Parents Father Only Mother Only Father/Stepmother Mother/Stepfather Foster Parents Guardian Relative:__________ Other: ______________

FAMILY STATUS

☐ *Father* ☐ *Step-Father* ☐ *Legal Guardian* ☐ *Foster Parent*

Name:______________________________

Living in Household: ☐ Yes ☐ No

Address: ______________________________

____

Home Phone: ______________ Cell: ______________

E-Mail: ______________________________

Employer: ______________________________

Work Phone: ______________

FAMILY STATUS

☐ *Mother* ☐ *Step-Mother* ☐ *Legal Guardian* ☐ *Foster Parent*

Name:______________________________

Living in Household: ☐ Yes ☐ No

Address: ______________________________

____

Home Phone: ______________ Cell: ______________

E-Mail: ______________________________

Employer: ______________________________

Work Phone: ______________

OTHERS LIVING IN HOUSEHOLD

Name	Relationship to Student	Sex	Age	School	Grade

Please print clearly and answer all questions completely.

CUSTODY INFORMATION

☐ Two Parents in Home ☐ Custody/Placement Transfer ☐ Single Parent

☐ Joint Custody ☐ Separated ☐ Emancipated

☐ Sole Custody ☐ Foster Placement (DSS-2999/3424 must be provided

RESTRICTIONS OF CONTACT & INFORMATION (Paperwork MUST be provided)

☐ Custody Papers Specify Restriction ☐ No Restrictions for Parents/Guardians ☐ Copy of Papers Provided

Restriction: ______________________________

☐ Order of Protection Against:______________ Expires:______________

☐ Other Restriction: ______________

EMERGENCY CONTACT INFORMATION (Other than Parent/Guardian)

1st Contact: ______________ Phone: ______________ Relation to Student: ______

Address: ______________________________
Street Name *Apt. #* *City* *State* *Zip*

2nd Contact: ______________ Phone: ______________ Relation to Student: ______

Address: ______________________________
Street Name *Apt. #* *City* *State* *Zip*

3rd Contact: ______________ Phone: ______________ Relation to Student: ______

Address: ______________________________
Street Name *Apt. #* *City* *State* *Zip*

LANGUAGE INFORMATION

Primary Language Spoken at Home: ______________ **Student's Primary Language:** ______________

If language is other than English, does the student read/write/speak English? ☐ **Yes** ☐ **No**
(Circle all that apply)

IMMIGRANT INFORMATION

Date of Entry into U.S. ______________ No. of Years In US Schools: ______________

Country of Origin: ______________

HOUSEHOLD/RESIDENCY STATUS

What is the current housing arrangement for the above named student(s)? Students who are in temporary housing may be protected by the McKinney-Vento Act. Students who are protected under this act may be entitled to other services. The answers you give will help the district determine what services you or your child may be eligible to receive.

☐ Permanent (Check one below)

Residence Type: ☐ Lease ☐ Own ☐ Rent ☐ Trailer park/Condo Unit Move in Date: ______________

☐ Temporary (Check one below)

☐ with another family/doubled up (due to economic hardship and not as a matter of convenience)

☐ In a shelter ☐ In a hotel/motel ☐ In an abandoned building

☐ In a car, park, bus, train, or campsite

☐ Other ______________

______________________________ Date: ______________
Signature of Parent/Guardian

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

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

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

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

Home Language Questionnaire (HLQ)

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

Please write clearly when completing this section.

STUDENT NAME:

First | Middle | Last

DATE OF BIRTH:

Month | Day | Year

GENDER:
❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name | First Name | Relation to Student

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other ______ (specify)	
2. What was the first language your child learned?	❑ English	❑ Other ______ (specify)	
3. What is the Home Language of each parent/guardian?	❑ Mother ______ (specify)	❑ Father ______ (specify)	❑ Guardian(s) ______ (specify)
4. What language(s) does your child understand?	❑ English	❑ Other ______ (specify)	
5. What language(s) does your child speak?	❑ English	❑ Other ______ (specify)	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other ______ (specify)	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other ______ (specify)	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:	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: ❑ Mother ❑ Father ❑ Other:______________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ______________________ POSITION: ______________________

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

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

NAME: ______________________ POSITION: ______________________

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: ______________ (MO DAY YR)

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ______________________ POSITION: ______________________

DATE OF NYSITELL ADMINISTRATION: ______________ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

Student Residency Questionnaire*
Hornell City School District

* This questionnaire should be completed for each newly registering student as well as each time a student changes his or her address. Multiple students may go on one form as long as they are all in the same school building in Hornell and all students are residing in the same place.
*** MUST PROVIDE PROOF OF ADDRESS ANY TIME YOU CHANGE YOUR ADDRESS**

Check All That Apply: ☐ New Registrant ☐ Transferring From Another District ☐ Change Of Address

Name Of Student (Last, First, Middle)	Name Of Hornell School	Grade	Gender	Date Of Birth	If Transferring, Last District Attended

Current Address: ____________________

Former Address (required for change of address and transferring students): ____________________

____

Current Telephone Number(s): ____________________

What is the current housing arrangement for the above named student(s)?

☐ ***Permanent*** (You do not need to complete the rest of this form)
☐ ***Temporary while we work out other arrangements*** (please complete the remainder of this form)

Students who are in temporary housing may be protected by the McKinney-Vento Act. Students protected by the act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificates. Students who are protected under this act may also be entitled to other services. The answers you give below will help the district determine what services you or your child may be able to receive.

☐ In a shelter ☐ In a hotel/motel ☐ In a car, park, bus, train, or campsite

☐ ***Temporarily*** sharing housing of other persons due to loss of housing or economic hardship

☐ In other ***temporary*** housing situation (please describe)____________________

____

Name of Parent, Guardian, or Student (if unaccompanied, homeless youth):

Printed Name	Signature	Date

Guidance Office:
If the student lives in anything other than permanent housing, please send a copy of this form to the district's McKinney-Vento Liaison. If the student is living in temporary housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district's liaison is required to assist the student in obtaining the necessary documents after the student has been enrolled.
Is this family having difficulty obtaining documents? ☐ Yes ☐ No
Does this family wish to be contacted by the McKinney-Vento Liaison about possible services? ☐ Yes ☐ No

I certify the above named student(s) qualified for the Child Nutrition Program under the provisions of the McKinney-Vento Act. A STAC-02 form will be filed by my office.

Date ____________ McKinney-Vento Liaison Signature ____________________

HORNELL
CITY SCHOOL DISTRICT

25 Pearl Street • Hornell • New York • 14843

Jeremy Palotti., Superintendent
Phone 607•324•1302
FAX 607•324•1345

Schools

Senior High	324-1303
Intermediate	324-1304
Bryant	324-2171
N. Hornell	324-0014

CONSENT TO RELEASE AND ACQUIRE INFORMATION

To any treatment agency, I hereby authorize the release and discussion of records by the Hornell City School District.

I also authorize the Hornell City School District to acquire and discuss records including, but not limited to, psychological, psychiatric, medical, attendance, probation, discipline, court related, report cards, speech, counseling, occupational therapy and physical therapy, which pertain to the programming and placement of:

______________________________ ____________

STUDENT NAME Date of Birth

______________________________ ____________

PARENT SIGNATURE Date

____

Phone Number(s)

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STUDENT NAME: ______________________________

MEDIA, WEB PHOTO AND INTERNET RELEASE:

MEDIA RELEASE

Local newspapers and occasionally TV stations attend school events or interview students about important issues. This may include artwork by your student, photographs, interviews and/or recording that may be published in newspaper, television informational material and/or the district website and BOCES publications. Please check the appropriate space granting or denying your permission.

__________YES, PERMISSION GRANTED __________NO, PERMISSION DENIED

WEB PAGE RELEASE

The school district website includes photographs of students. These children are not identified by name. Please check the appropriate space granting or denying your permission.

__________YES, PERMISSION GRANTED __________NO, PERMISSION DENIED

INTERNET ACCESS

The Hornell City School District uses a BOCES operated internet filtering service that prevents the display of content inappropriate for students. The content that students will be denied access to includes sexually explicit material, graphically violent material, material relating to hate groups and their message, profanity, chat sites, and sites that gather personal information. Material advocating illegal activity such as drug use, bomb making, underage drinking and gambling, information on committing murder or suicide and sites that promote plagiarism or cheating are also inaccessible to anyone using the district's network. While we are very satisfied with our filtering software, you should know that no solution is perfect. All filtering software may block innocent sites and allow some inappropriate sites to slip through. Using the internet is a privilege, not a right. The district expects your child to show respect for technology and use it appropriately or they will forfeit this opportunity.

As the parent or legal guardian of the minor named on this document, I am granting permission for my child to access the internet under adult supervision. I also understand that individuals and families may be held liable for violations and I am accepting responsibility for conveying standards for my child to follow when selecting, sharing or exploring information on the internet.

______________________________ ______________

PARENT /GUARDIAN SIGNATURE Date

HORNELL CITY SCHOOL DISTRICT 25 Pearl Street • Hornell • New York • 14843

North Hornell – 324-0014
Bryant – 324-2171
Intermediate School -324-1304
Junior/Senior High – 324-1303

Health Services Guidelines

1. **School Physicals**: A physical is necessary for all students entering into public school as mandated by New York State for the following: **All New Entrants, Pre-K/K, 1st, 3rd, 5th, 7th, 9th and 11th** grade students. If your child has had a physical within a year of the first day of entering please be sure to provide a copy to your school nurse. Physicals are to be done by a physician licensed to practice in New York State and shall include **BMI** (body mass index) and **WSC** (weight status category) information which will be reported to NYS without the use of names. Parents may opt out of having their child's WSC reported to NYS by signing an "opt out" request and returning it to the respective school health office.
Physicals are offered at school for newly enrolled students, students in the mandated years, playing sports (required annually) and for working papers.

2. **Immunization record**: An **official** immunization record from a physician's/public health office is required for entry in NYS schools. This record **must be produced within 14 calendar days of admission** to school, **30 days if coming from out of state.**
New York State Department of Health requires that each student comply with the following immunization requirements: HIB-Pre-K 1-4 doses, PCV- Pre-K 1-4 doses, DTP-4 or more doses , Polio- Pre-K 3 doses, K-12- 4 or more with the 4th dose being given no more than 4 days before the 4th birthday but before the 7th birthday, MMR- Pre-K 1 dose, K-12- 2 doses , Hepatitis Series- 3 doses, Varicella(chicken pox)- Pre-K,5th,11th and 12th- 1 dose, 2 doses for all others, and TDAP- 1 dose for all students entering grades 6 - 12. **ALL STUDENTS ENTERING: 7th, 8th, 9th and 12TH grades- MUST have the MENINGOCOCCAL VACCINE – THEY CAN NOT START SCHOOL WITHOUT IT.** Again if you have already provided proof of this to the school nurse thank you, nothing further needs to be done.

3. **Hearing, Vision and Scoliosis**: The school nurse will do vision screening for all new students as well as students in grades Pre-K/ K,1,3,5,7 ,11 and upon request. Scoliosis screenings will be done for girls in grades 5 & 7 and boys in grade 9, any abnormal finding will be reported to the students' parent/guardian.

4. **Physical Education Restrictions**: NYS requires that all students participate in physical education. If your child has an illness or injury which prevents them from performing normal activities, please ask their physician to document what they can do safely and bring the note to the nurse's office. When your child can return to normal activities a written release from the doctor is also required to be brought in.

5. **Medication**: Any medication that must be taken during school hours must be brought to the nurses office in its original container with the label intact. A parent should bring the medication to school with a permission form signed by the physician and the parent. The medication will be kept in the nurses office and administered at the proper time. Even over the counter medications such as: Tylenol, Advil, cold formulas, topical, eye medication, etc. must be ordered by a physician and signed by a parent in order to be given in the school setting.

HORNELL CITY SCHOOL DISTRICT

25 Pearl Street • Hornell • New York • 14843

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (HIPPA)

Student Name_______________________________________ Birthdate: ____________

Healthcare Provider (doctor) ____________________________ Phone: ______________
Address____Fax:_______________
Healthcare Provider (doctor) ____________________________ Phone: ______________
Address____Fax:_______________
Healthcare Provider (doctor) ____________________________ Phone: ______________
Address____Fax:_______________

I hereby authorize my/my child's physician(s) listed above to exchange the following information with the Hornell City School District, including:

- ☐ School Nurse
- ☐ Medical Officer
- ☐ Physical Therapist
- ☐ Occupational Therapist
- ☐ Speech Therapist
- ☐ Audiologist
- ☐ Vision Department
- ☐ Special Education
- ☐ Other __________

- ☐ Immunizations to comply with NYS regulations
- ☐ Physical exams to comply with NYS regulations and sports requirements
- ☐ Authorization for medications during the school day or on school bus
- ☐ Medical clearances as needed following an injury or change in condition
- ☐ Medical orders required for therapy needs, evaluations
- ☐ Physician referral for services (OT, PT)
- ☐ Medical condition/treatment plans that may have an impact in the school environment
- ☐ Other ______________________________

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon signing this release however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment.

This release expires on the last day of the enrollment of the above student in the Hornell City School District, and may be revoked at any time by sending a written and signed request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt by the District. Protected health information will not be disclosed without consent pursuant to the Family Educational Rights and Privacy Act (20 U.S.C § 1232g) and implementing regulations (34 C.R.F. §99). A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the Hornell City School District by the healthcare providers listed above.

_______________________________________ ____________
(Signature of student over 18 or Parent/Guardian)** (Date)

** If student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, state authority to act on student's behalf: ______________. ** If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act and the information requested pertains thereto, then the parent/guardian must also sign consent form.

Return completed form to the **NURSE** at the school this child attends.

HORNELL
CITY SCHOOL DISTRICT

25 Pearl Street ● Hornell ● New York ● 14843

Jeremy Palotti, Superintendent
Phone 607•324•1302
FAX 607•324•1345

MEDICAL INFORMATION & EMERGENCY FORM

Student/Minor Information:

Name (first, middle, last)____
Address:____

Student/Minor's Primary Physician:
Name (first, middle, last):______________________________ Phone (_____) ______________

Medical Conditions:

Please list any medical conditions of the student/minor (ex. asthma, diabetes, epilepsy, etc.) ______________________
____

List any allergies or allergic reactions to medications of the student/minor:______________________
____

List any medications the student/minor is currently taking:______________________

Other pertinent medical information: ______________________

Date of student/minor's most recent tetanus shot: ______________________

EMERGENCY CONTACTS:

Parent or Guardian
Name (first, middle, last) ____
Daytime phone: (_____)______________ Cell Phone (_____) ______________ Evening phone: (_____)______________
Relationship to student/minor:______________________

Other contact
Name (first, middle, last) ____
Daytime phone: (_____)______________ Cell Phone (_____) ______________ Evening phone: (_____)______________
Relationship to student/minor:______________________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school. Should the need arise this information will be given to the proper medical authorities.

I, ______________________________ (parent/guardian) understand that in the case of illness or injury to my child ______________________________ (child's name), the school will try to notify me or the person I have listed on the other side of this form as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school to (1) arrange for transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and (2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

______________________________ ______________
Signature of parent/guardian Date

Hornell City School District

Permission to Administer Medication

Student Name: ______________________________ DOB:__________________________

Grade: __________ Teacher/HR: ___________________________________ School: ___________________

To Be Completed By Health Care Provider

Diagnosis ____

Medication _________________________________ Dose ___________ Route _________ Time(s) _________

Duration- start date-________________stop date-________________ ICD Code __________________

All medication should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Please check all that are applicable:

❑ If morning dose is not given at home, nurse may administer morning dose of ___________ after verbal or written notification from parent. Please advise parent to send in additional medication

❑ Medication is required: ❑ On bus ❑ On field trips❑On school-sponsored after school/weekend activities/sports

❑ I assess this student to be **self-directed*** regarding this medication.
*They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

❑ I have determined this student is consistent and responsible in taking their own medications (Self-Directed)and in addition, give them permission to **self- carry and self-administer** this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name, Title and License Number of Prescriber (Please Print)____

Prescriber's Signature ______________________________Date ____________Phone ____________________

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature ______________________________ Date _____________ Phone _________________

Additional Permission for Self –Administer/Self Carry (Requires Health Care Provider Consent Above)

Parent permission and provider consent is required for students to self-administer and self-carry medication. **Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse.** Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature ______________________________ Date _____________ Phone _________________

School Nurse: ____ School ____

Phone: ___________________________ Fax: ________________________

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports and working permits

HEALTH CERTIFICATE / APPRAISAL FORM

Name: ______________________ Date of Birth: ______________

School: ______________ Gender: ☐ M ☐ F Grade: ______________

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: ______
PPD: ☐ Positive ☐ Negative ☐ Not done Date: ______
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: ______
Dental Referral ☐ Yes ☐ No ☐ Not done Date: ______

Significant Medical/Surgical History: ☐ See attached ______________

Allergies: ☐ LIFE THREATENING ☐ Food: ______ ☐ Insect: ______ ☐ Other: ______
☐ Seasonal ☐ Medication: ______

PHYSICAL EXAM

Height: ______ Weight: ______ Blood Pressure: ______ Date of Exam: ______

Body Mass Index: ___ ___ . ___				Referral
Weight Status Category (BMI Percentile):	Vision - without glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - with glasses/contact lenses	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Vision - Near Point	R	L	
	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: ______

Specify any abnormality (use reverse of form if needed): ______________

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: ______________ Dosage/Time: ______________
Name: ______________ Dosage/Time: ______________

If AM dose is missed at home: ______________

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** ______________ ☐ None
☐ **Known or suspected disability:** ______________ ☐ Please monitor
☐ **Restrictions:** ______________ ☐ Please monitor
☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: ______

OPTIONAL INFORMATION, if known

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: ______________

Provider's Signature: ______________ Phone: ______________ (Stamp below)

Provider's Name/Address: ______________ Fax: ______________

Parent Signature: ______________ Date: ______________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*

2018-2019 Community Eligibility Provision
Household Income Eligibility Form

Hornell City School District is participating in the Community Eligibility Provision. All children in the school will receive meals at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call 607-324-1303, ext. 1570, if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here, and sign the application.

Name: ______________________ CASE # ______________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: Date:

Email Address:

Home Phone

Work Phone

Home Address

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAP/TANF/Foster Income Total Household Income/How Often: Household Size:

Free Eligibility Reduced Eligibility Denied Eligibility

Signature of Reviewing Official

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1 — **ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.**

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2 — **HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.**

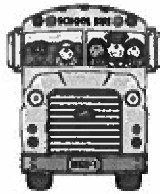
(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 4. **SKIP PART 3 -** Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4 — **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.

PRIVACY ACT STATEMENT

Confidentiality: The United States Department of Agriculture has approved the release of students names and eligibility status, without parent/guardian consent, to persons directly connected with the administration or enforcement of federal education programs such as Title I and the National Assessment of Educational Progress (NAEP), which are United States Department of Education programs used to determine areas such as the allocation of funds to schools, to evaluate socioeconomic status of the school's attendance area, and to assess educational progress. Information may also be released to State health or State education programs administered by the State agency or local education agency, provided the State or local education agency administers the program, and federal State or local nutrition programs similar to the National School Lunch Program. Additionally, all information contained in the free and reduced price application may be released to persons directly connected with the administration or enforcement of programs authorized under the National School Lunch Act (NSLA) or Child Nutrition Act (CNA); including the National School Lunch and School Breakfast Programs, the Special Milk Program, the Child and Adult Care Food Program, Summer Food Service Program and the Special Supplemental Nutrition Program for Women Infants and Children (WIC); the Comptroller General of the United States for audit purposes, and federal, State or local law enforcement officials investigating alleged violation of the programs under the NSLA or CNA.



Hornell City School District
Transportation Department
25 Pearl Street, Hornell, NY 14843
(607) 324-2633

**********************************APPLICATION INSTRUCTIONS***************************************

This application is used for student school bus transportation arrangements for the 2018-19 school year. With our continued focus on students' safety, we will not be able to take permanent transportation information over the phone. For your child's protection, we require detailed information regarding pick-up and drop-off arrangements with a parent or guardian's signature.

- A separate application is required for **EACH** student.
- A new application is required for **ANY** change that is made during the school year.
- A new application is required **EVERY** school year.
- **Failure to turn in an application will mean your child will not be scheduled for transportation.**

Due to the overwhelming amount of requests being processed, we require that all completed forms be returned to the District Office at 25 Pearl Street, Hornell, NY 14843. It will be forwarded to the bus garage as permanent instructions for the transportation of your child to and from school for the 2018-2019 school year. If your child will not need transportation, please indicate on the form and return to school or bus driver.

Students in grades PK-6 are eligible for transportation if they live 7/10ths of a mile or more from their school of attendance. Students 7-12 are eligible for transportation if they live 1.5 miles or more from their school of attendance.

We can accommodate <u>one change per semester</u>, if necessary. **If a change needs to be made, please contact our office as soon as possible to complete a new form.** We can be reached between 7:00 a.m. and 3:00 p.m. at 324-2633. **A minimum of three (3) school days is required to make a schedule change.** We are not allowed to transport students to any other address than is noted on this form. **<u>WE CANNOT MAKE BUS CHANGES TO A DIFFERENT ADDRESS FOR PLAY DATES/SOCIAL DATES</u>.** Once a schedule is established, it must remain consistent. Emergency situations may arise, please contact the bus garage at 324-2633 and we will attempt to assist with an emergency change. If your address changes, you must make the change through the "Parent Portal" or by calling the district office 607-324-1302 x 1109 and then notify the bus garage.

Students are required to arrive at their bus stop at least 5 minutes before the bus arrival time. Please remember that the first few weeks of school are hectic and buses may not be on "schedule". Therefore, your child may arrive home later than usual. Times may fluctuate according to traffic and weather conditions. School delays and cancellations are announced through our mass notification system as well as on all Hornell radio stations, local area television stations and the Hornell City School website (www.hornellcityschools.com).

PLEASE NOTE: YOU MUST STILL COMPLETE A FORM FOR YOUR CHILD(REN) EVEN IF YOU ARE NOT REQUESTING TRANSPORTATION SERVICES FROM THE DISTRICT. THERE IS A PLACE FOR YOU TO INDICATE THEY DO NOT REQUIRE TRANSPORTATION.

Hornell City School District
Transportation Department
25 Pearl Street, Hornell, NY 14843
(607) 324-2633

Directions: **PLEASE PRINT**

1. Complete an application for **EACH** child.
2. **A new application must be completed each year**
3. **Students may only have 1 pickup and 1 drop off point**
4. Daycare / Alternate site address must be located within the Hornell City School District.
5. If arrangements change, a new application must be completed.
6. Incomplete forms will not be processed.

My child does NOT require transportation by the district: ☐
My child DOES require transportation by the district IF eligible: ☐

Student Information:
Child's First Name: ______________________ Last Name: ____________________ Grade: __________

Contact Name: ____________________________________ Phone: ____________________
Primary/Home Location Information:

Address: ____________________________________ City: ________________

Please circle the appropriate days below that student **will be transported to/from primary (home) location.**

AM home to school	PM school to home
M T W TH F	M T W TH F

Daycare or Alternate Information:

Daycare Contact Name: _________________________ Phone: ____________________

Address: ____________________________________ City: ________________

Please circle the appropriate days below that student **will be transported to/from Daycare or Alternate Site**

AM from daycare or alternate site to school	PM to daycare or alternate site
M T W TH F	M T W TH F

Parent / Guardian Information:
Name of Parent / Guardian: ________________________________

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Parent / Guardian Signature: ________________________________ Date: ____________________

By signing above, you are indicating that you have verified that your child's address and contact information is accurate and current with the district by confirming through the parent portal or other district correspondence.