

Newark Valley Central Schools Nathan T. Hall - Registration Form

Completed by School

Student's Legal Name _____ Today's Date _____

Name or Nickname to be used _____

Birth Date _____ Birth Place _____

Complete Mailing Address _____ Home Phone _____

Apt# _____ Lot# _____ Town _____ State _____ Zip _____

Home Location _____ between _____ and _____

(Road/street) (Road/street) (Road/street)

Home Description (include where you live on your road/street and color, style and trim of home)

Bus Pick-up Location (please circle): Home Alternate Drop-off: Home Alternate

If Alternate: Name _____ Phone _____

Address & Description _____

Please complete this information so the school can contact you (e.g., emergencies, conferences):

Please list all persons currently living at the above address and write in their relationship to the above student, such as: (natural, step, half, adopted, or foster) parent/brother/sister, aunt/uncle, grandparent, friend, etc. (e.g., natural father, step-brother).

Please list those who have legal custody for the above student:

| Full Name | Sex | Relationship to Student | Birthdate | Grade |
|-----------|-----|-------------------------|-----------|-------|
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| | | | | |

Custodial Parent/
Guardian/Adult Name _____ Cell phone _____

Custodial Parent/
Guardian/Adult Name _____ Cell phone _____

Work Place _____ Phone _____

Work Place _____ Phone _____

Email address _____

Email address _____

Best time and number to reach you during the day:

Best time and number to reach you during the day:

In case of emergency and parents/guardians/adults at above address cannot be reached, person(s) to call:

_____ Phone _____

_____ Phone _____

PLEASE COMPLETE REVERSE SIDE

SCHOOL TO COMPLETE

| Records submitted: | Requested | Received | Records submitted: | Requested | Received |
|---------------------------|-----------|----------|--------------------|-----------|----------|
| Transcript of Subjects | _____ | _____ | Birth Certificate | _____ | _____ |
| Health Records | _____ | _____ | CSE/CPSE Records | _____ | _____ |
| Legal Documents (custody) | _____ | _____ | Proof of Residency | _____ | _____ |

Name & Home address for non-custodial parent _____

Home Phone: _____ Work Place: _____ Work Phone: _____

Are there any legal documents (or court orders) involving this parent's custody rights? Yes _____ No _____ If yes, please provide the school with all legal documents.

List other family members currently NOT living at above address with student (e.g., separated, divorced, step-parents, siblings no longer at home):

| Full Name | Sex | Relationship to Students | Birthdate or age | Grade |
|-----------|-----|--------------------------|------------------|-------|
| | | | | |
| | | | | |
| | | | | |

Is a language other than English spoken in your home? Yes _____ No _____ (if yes, fill out Form A-14/Home Language Questionnaire)

What is this student's general attitude about school or, if entering K, beginning school? _____

If entering K-3, has this student ever attended Pre-school, Nursery School, or Head Start? Yes _____ No _____

List program and age(s) of attendance: _____

Has this student ever attended Newark Valley Central School? Yes _____ No _____ (If yes, list grade(s) attended):

Name, address and phone number of last school attended: _____

Has this student ever attended any other school district? Yes _____ No _____ (If yes, list schools and grades attended):

Has this student ever been in special education program? Yes _____ No _____

Has this student ever been reviewed by the Committee on Special Education (CSE) or the Committee on Preschool Special Education (CPSE)?

Yes _____ No _____

Has this student ever received: Speech/Language Therapy Yes _____ No _____ Remedial (AIS) Reading Yes _____ No _____
 Occupational Therapy Yes _____ No _____ Remedial (AIS) Math Yes _____ No _____
 Physical Therapy Yes _____ No _____ Remedial (AIS) Writing Yes _____ No _____

Has this student ever been evaluated for any special education, remedial, or preschool services? Yes _____ No _____

If yes to any of the special education/remedial questions, please note where and when: _____

Is there any other information or special concerns you would like to share with us regarding this student? _____

Has your child ever been in a Gifted or Talented Program? Yes _____ No _____ (If yes, which grade, year and for what program?) _____

We greatly appreciate your time in completing this registration form.

Signature _____ Relationship to student _____

NEWARK VALLEY CENTRAL SCHOOLS



Registration Form Addendum

Name of School: Nathan T. Hall Elementary Middle School High School

Student Name _____
Last, First, Middle

School Districts are required to collect the following data for use for State and/or Federal Reporting.

REGARDING RACE/ETHNICITY:

For this question check (✓) the box that best describes your child. Check only ONE box.

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

For this question, check (✓) ALL groups that apply to your child. Check **at least** one box.

Select one or more races from the following five racial groups:

- 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 OF 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.

Signature of Parent/Guardian/Other

Date

Relationship to Student (please check one box): Mother Father Guardian

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Male Female Date of Birth: ____/____/____ Grade: ____ ID#: ____
Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or 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 the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): _____
- In permanent housing

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

Date

If **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

STUDENT HEALTH HISTORY UPDATE

| | | | |
|---------------------------------------------------|--------|-------------|------------------------------------------------------------------|
| Name: | DOB: | Age: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
| Parent/Guardian: (person completing this form) | Grade: | Home Phone: | Date: |
| | | Cell Phone: | |

| Has your child ever: | YES | NO | If Yes, please explain and include date: |
|----------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Had an ongoing medical condition | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seen a medical specialist | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had allergies: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other |
| Been hospitalization | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had an operation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had an injury requiring an Emergency Room visit | <input type="checkbox"/> | <input type="checkbox"/> | |
| Missed 5 days of school in a row due to illness/injury | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had a bone/muscle injury | <input type="checkbox"/> | <input type="checkbox"/> | |
| Passed out, had a concussion or serious head injury | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had a convulsion/seizure | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had a vision problem or condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> glasses <input type="checkbox"/> contacts |
| Had a hearing problem or condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant |
| Worn dental bridge, braces or mouthpiece | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have any family members under the age of 50 ever: | YES | NO | If Yes, please specify: |
| Had a heart attack | <input type="checkbox"/> | <input type="checkbox"/> | |
| Had other serious health problems | <input type="checkbox"/> | <input type="checkbox"/> | |

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> ADHD <input type="checkbox"/> Asthma/trouble breathing <input type="checkbox"/> Autism/Asperger <input type="checkbox"/> Dental Injuries <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infections | <input type="checkbox"/> GI Conditions (ulcer, reflux, IBS) <input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Heart Conditions <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Mental Health Condition (depression, eating disorder, | anxiety, OCD, ODD, etc.) <input type="checkbox"/> Scoliosis <input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle) <input type="checkbox"/> Skin Condition <input type="checkbox"/> Speech Condition <input type="checkbox"/> Urinary Condition |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| CURRENT MEDICATIONS | YES | NO | Please list name, dose, time(s) |
|-----------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Given at school | <input type="checkbox"/> | <input type="checkbox"/> | |
| Taken at home | <input type="checkbox"/> | <input type="checkbox"/> | |
| ASSISTIVE EQUIPMENT | YES | NO | Please check all that apply |
| During or outside of school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other: |
| TREATMENTS | YES | NO | |
| During or outside of school | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet |

Is there any condition that would prevent your child from participating in physical education or sports?
 No Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____

PARENTAL CONSENT FORM

INTERNET USAGE

Please return this agreement to the principal indicating your permission or denial of permission for your student to use the school Internet access.

Dear Parent or Guardian,

One of the goals of our students is to effectively acquire and use information. As part of this information handling, it is necessary to provide access to electronic communication. Please realize that some resources on the Internet are uncensored and inappropriate for student use. The Newark Valley School District will not be held responsible for these materials. The purpose of electronic communication is for educational use only. Access of inappropriate resources at school will result in loss of all computer privileges. All attempts will be made to monitor and supervise student use, but students will ultimately be held responsible for their own behavior.

I give permission for _____ to use a student account at the Newark Valley Central School District which will provide him/her access to the Internet, a worldwide network of school computers. I agree that my child will use this account responsibly for educational purposes only. I have discussed with my child the Board adopted policy regarding acceptable use of the Internet.

I do not give permission for _____ to use a student account at the Newark Valley Central School District.

Student Last Name _____ First Name _____

Signature of Parent or Guardian _____ Date _____

Print Name: Parent or Guardian _____

Signature of Student (6th-12th grade) _____ Date _____

You may grant or deny permission at any time by contacting the principal and completing a new form.

NEWARK VALLEY CENTRAL SCHOOL DISTRICT
PUBLICATION RELEASE

Date _____

I give my permission as parent or guardian of _____ to print or publish pictures or films taken of the activities or work of this student.

Signature _____ Print Name _____

District Office
68 Wilson Creek Road
Newark Valley, NY 13811
Phone: (607) 642-3221
Fax: (607) 642-8821

Newark Valley High School
68 Wilson Creek Road
Newark Valley, NY 13811
Phone: (607) 642-8665
Fax: (607) 642-5292

Newark Valley Middle School
88 Whig Street
Newark Valley, NY 13811
Phone: (607) 642-5524
Fax: (607) 642-8494

Nathan T. Hall Elementary
86 Whig Street
Newark Valley, NY 13811
Phone: (607) 642-3340
Fax: (607) 642-5004