NIAGARA FALLS CITY SCHOOL DISTRICT

630 66TH STREET

NIAGARA FALLS, NY 14304

CENTRAL STUDENT REGISTRATION

716-286-4263 (PHONE) ~ 716-286-4240 (FAX)

jdavidson@nfschools.net

Document Required **Date Received**

Completed Registration Packet_____

Birth Certificate (can be requested from previous school)_____

Parent/Guardian Valid Photo I.D._____

Proof of Residency

(utility bill, lease, notarized statement of address from landlord, or social services verification of address)_____

Legal Custody Papers or Petition_____

Info for Previous School

(grades 1-6)_____

Last Report Card

(checkout/withdrawal grades)_____

Transcript

(grades 9, 10, 11, 12)_____

Immunization Records (can be requested from previous school)_____

Physical_____

Current IEP or 504 Plan_____

Please note:

Children in Pre-K WILL NOT BE REGISTERED without a current physical and immunizations.

Children in grades K-12 can be registered without a current physical, but may be removed from school if one in not received within 20 days of starting school.

Children in grades 9-12 WILL NOT BE REGISTRED until their transcripts are received from their previous school.

Your home school is_____

NIAGARA FALLS CITY SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Rev. 9/29/10

FOR OFFICE USE ONLY **Roll Call/Homeroom #** _____

Date of Entry _____ **Student ID Number** _____ **Teacher** _____

Child's
Legal Name _____
Last Name *First Name* *Middle Name*

Home Address _____ **Apt. #** _____ **Zip** _____

☐ **Female** ☐ **Male** **Date of Birth** _____ **Grade** _____

Year started 9th grade _____
Special Education _____ **Yes** _____ **No** **504 Plan** _____ **Yes** _____ **No**
(If Yes, refer to PSA)
U.S. Citizen _____ **Yes** _____ **No (If no, citizen of what country?)** _____

ESL: _____ **Yes** _____ **No (If yes, what is Native Language:** _____**)**

Parent E-Mail address for school contact _____

Ethnicity (Check One)	**Race (Check one or more, regardless of Ethnicity)**
☐ **Hispanic/Latino**	☐ **American Indian or Alaska Native** ☐ **White**
☐ **Non-Hispanic/Latino**	☐ **Black or African American** ☐ **Asian**
	☐ **Native Hawaiian or Other Pacific Islander**

Previously registered in the Niagara Falls School System? ☐ **Yes** ☐ **No**

Last School Attended _____ **Date Left** _____ **Grade(s) Repeated** _____

Address of Last School _____
(If NOT in Niagara Falls) **Street** **City/State** **Zip**

Phone Number of Last School _____ **Fax Number** _____

Student resides with: ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Other** **Legal/Custody Papers? Yes** ___ **No** ___

If Other: Name and Relationship _____

Mother's Name (if applicable) _____ **Home Phone** _____

Address (if different from student) _____ **Cell Phone** _____

Place of employment _____ **Work Phone** _____

Father's Name (if applicable) _____ **Home Phone** _____

Address (if different from student) _____ **Cell Phone** _____

Place of employment _____ **Work Phone** _____

Student's Guardian's Name _____ **Home Phone** _____

Guardian's Address _____ **Cell Phone** _____

Place of Employment _____ **Work Phone** _____

(OVER)

PERSON (S) TO BE CONTACTED IN CASE PARENT CANNOT BE REACHED (Please list 2)

(1)Name_____ **Relationship**_____

Address_____

Phone Number _____ **Cell Phone** _____

(2)Name_____ **Relationship**_____

Address_____

Phone Number _____ **Cell Phone** _____

Student's Brothers / Sisters (PreK – Grade 12):

Name	**Age**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FOR OFFICE USE ONLY

Registration Checklist (Check, NA, or initial)

☐ **Proof of Residency**	☐ **Birth Certificate**	☐ **Special Needs - PSA**
☐ **Health History Form**	☐ **Immunizations**	☐ **Home Language Questionnaire**
☐ **Mc-Kinney-Vento Questionnaire**	☐ **Student Media Form**	☐ **Computer Usage Form**
☐ **Charter School Sign Off**	☐ **Release of Information Form**	☐ **Schedule**
☐ **Alternate Transportation**	☐ **Lunch Application**	

Registrar _____ **Date** _____

Computer Input _____ **Date** _____

Administrator Approval _____ **Date** _____

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 ☐ Non-binary

Date of Birth: _____ /_____ /_____ (Month / Day / Year)

Grade: _____ (preschool-12)

ID#: _____ (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.

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:

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
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(518) 474-8775 / Fax: (518) 474-7948

Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal.
Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO:

Mes *Día* *Año*

GÉNERO:
❑ Masculino
❑ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas
(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	❑ Inglés	❑ Otro _____ *especifique*	
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	❑ Inglés	❑ Otro _____ *especifique*	
3. ¿Cuál es el idioma primario de cada padre / tutor?	❑ Madre _____ *especifique*	❑ Padre _____ *especifique*	❑ Tutor(es) _____ *especifique*
4. ¿Qué idioma o idiomas entiende su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	
5. ¿Qué idioma o idiomas habla su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)?	❑ Inglés	❑ Otro _____ *especifique*	❑ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

*Sí** ❑ *No* ❑ *No se sabe* ❑ * En caso afirmativo, por favor explique :_____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ❑ Poca gravedad ❑ Algo grave ❑ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ❑ **No** ❑ **Sí*** * *Por favor, llene 10b.*

10b. *<u>Si se le ha recomendado alguna vez una evaluación,</u> ¿ha <u>recibido</u> su hijo(a) alguna vez alguna forma de educación especial?

❑ **No** ❑ **Sí – Explique, que forma o formas de educación especial recibió:**

_____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

❑ **De nacimiento a 3 años (Intervención Temprana)** ❑ **3 a 5 años (Educación Especial)** ❑ **6 años o mayor (Educación Especial)**

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ❑ **No** ❑ **Sí**

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(Por ejemplo, talentos especiales, problemas de salud, etc.)

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año: _____

Firma del padre/madre o de la persona en relación paternal ***Date***

Relación con el estudiante: ❑ **Madre** ❑ **Padre** ❑ **Otra:**_____

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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

City School District Of the City Of Niagara Falls
Consolidated Permission Form for Releasing Information to the US Military,
Using District Computer Systems, Online Art Gallery and Media Release and Publication on-line.

Please complete this form and return it to your child's school on or before September 30,
Put your **initials** in the appropriate box, **Yes** I give my permission or No I do not give my permission.

Student Name _____ Student ID Number_____

School _____ **Class/Homeroom Teacher** _____

☐ **Yes** ☐ **No**

Release of information to the US Military (Grades 11 and 12 only)
The No Child Left Behind Law of 2002 requires high schools to release the name, address, and phone number of any 11th or 12th grade student to the United States Military. In order to receive federal funding, the City School District Of the City Of Niagara Falls must comply with this mandate unless parents provide written notification via this form that they do not want this information released.

☐ **Yes** ☐ **No**

Computer Acceptable Use (all grades)
Parents and guardians can obtain a copy of the District's Acceptable Use Policy by visiting any school or www.nfschools.net. All student computer use must comply with this policy. Internet Safety is part of the State curriculum and learning to use technology responsibly is an important part of education. Unless a parent provides written notification via this form, students will have access to the District's computer system in accordance with the Districts AUP.

☐ **Yes** ☐ **No**

Online Art Gallery (all grades)
I give permission to the City School District Of the City Of Niagara Falls to share my child's artwork along with his/her **first name** on the Online Art Gallery on the School District's Website, www.nfschools.net

☐ **Yes** ☐ **No**

Photographs ,Videos, Interviews District Website Release (all grades)
I give my permission to City School District Of the City Of Niagara Falls that photographs, and/or video tapes and/or interviews of my child may be taken and used by the District only for public relations, educational, or other purposes consistent with the purposes and mission of the District, including use of any photograph and/or image and/or interview on the District Website or other District electronic resources such as social media. I understand that my permission allows the District to use my child's first and last name for public relations and educational purposes. I further agree that said materials will become the property of the District and I hereby release and discharge the District and it representatives from any
and all claims that may result by reason of taking of such photographs and/or videotapes and/or interviews.

☐ ☐

Yes **No**

Media Release (all grades)
I give permission to the City School District Of the City Of Niagara Falls to use my child's photograph, likeness and/or work and/or interviews in any compilations to be distributed within the community. Specifically photographs of students may be used in the District newsletter(s), in pamphlets or brochures, or on flyers. Such images may also be distributed to local media, either print or video, or may be used on the OSC-TV Channel 21, or be used or distributed in like manner.

If in the future you wish to reverse any permission, you may do so by notifying your child's principal in writing.

Parent/ Guardian Name: (Please Print) _____
Date_____

Parent/ Guardian Signature: _____

Niagara Falls City School District
Health Services

Date of Birth_____ Place of Birth_____ Gender at birth M____ F_____

Mothers Name_____ Address_____ Phone_____
Mothers Place of Employment_____ Work Phone_____
Fathers Name_____ Address_____ Phone_____
Fathers Place of Employment_____ Work Phone_____
Emergency: 1. Name_____ Phone_____
2. Name_____ Phone _____
Describe your child's current state of health (circle one) Excellent Good Fair Poor

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

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition
Females Age Menstruation began _____
Date of last menstrual period _____

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

All medications have side effects and for your child's safety, it is important for the School Nurse to have this information.
PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES AT HOME ONLY:

_____

_____

HAS YOUR SON/DAUGHTER:

Ever been a patient in a hospital? Yes ___ No ___ If yes Date _____ explain _____
Had any operations? Yes ___ No ___ If yes Date _____ explain _____
Had any accidents? Yes ___ No ___ If yes Date _____ explain _____
Is your son/daughter under a physician's care now? Yes ___ No ___ explain _____
Is he/she allergic to any medication? Yes ___ No ___
Has he/she participated in any psychological testing? Yes ___ No ___ If yes Date _____

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM

PLEASE ADD ANY ADDITIONAL PERTINENT FAMILY MEDICAL HISTORY: _____

_____

_____

PLEASE LIST ANY ADDITIONAL CONCERNS: _____

_____

Parent/Guardian Signature_____ Date _____

B. ***PLEASE LIST & SIGN FOR ALL MEDICATIONS YOUR CHILD WILL NEED AT SCHOOL.***

MEDICATION DOSE TIMES

_____

_____

_____

I request that my child receive the medication as prescribed by our health care provider. THE NEW YORK STATE EDUCATION DEPARTMENT REQUIRES THAT ALL MEDICATION IS TO BE FURNISHED BY ME IN A PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY AND MUST BE BROUGHT TO THE SCHOOL HEALTH OFFICE BY A PARENT OR GUARDIAN.
It is the policy of the School District of the City of Niagara Falls that these procedures must be followed or the school will not be responsible for the administration of the medication. I understand that the school nurse, will administer the medication.

I agree if my child's health care provided allows HIM/HER to self-carry the approved medication.

Yes _____ No _____ Parent Initials _____

If no medication at school skip this signature

Signature (Parent or Guardian) _____ Date_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

C. ***The below signature is optional:***

In order to share protected health information with the school district, your healthcare provider may require the completion of the statement below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete and sign the information below to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below to release
(Print name of parent/guardian)

My child's _____ medical records to the district's medical inspector or school nurse.
(Child's Name)

Health Care Providers Name _____ Phone _____

Health Care Providers Name _____ Phone _____

Health Care Providers Name _____ Phone _____

The healthcare provider may disclose the following protected health information: (Check all that apply)

☐ Immunizations
☐ Health Appraisals (Physical Exam)
☐ Current Medications listed in section B above
☐ Other_____

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM J-28 3/23

The Registration packet is NOT complete until we have ALL of the following:

Birth Certificate

Parent or Guardian I.D.

Proof of Residency

Custody or Guardianship documents (if pertaining)

Immunizations/Physical

You may submit any documents via email or fax:

jdavidson@nfschools.net or

716-286-4240

NIAGARA FALLS CITY SCHOOL DISTRICT
HEALTH SERVICES

Health and Dental Examination Requirements

Dear Parents/Guardians, Date:

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade.** Any physical examination completed on or after September 7, 2019, will be accepted if signed by a New York State licensed physician, physician assistant or nurse practitioner, and on the approved NYSED Student Health Examination form attached. **New York State Education Law, Section 903, was amended to read "Each Health Certificate shall also state student's body mass index (BMI) and weight status category... each school and school district shall participate in surveys directed by the commissioner of health pursuant to the public health law..." The Niagara Falls School District may be selected to report student weight status category information. PARENTS OR GUARDIANS MAY NOTIFY THE SCHOOL NURSE IN YOUR CHILD'S SCHOOL IF YOU WISH TO HAVE YOUR CHILD'S BMI AND WEIGHT STATUS CATEGORY EXCLUDED IN THIS ANONYMOUS SURVEY.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts Pre-K or K, 1st ,3rd, 5th, 7th, 9th & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If you are unable to obtain a physical exam from your child's health care provider (HCP) a health appraisal will be completed at school, by the District Medical Director/Nurse Practitioner. In order for the physical appraisal to be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained. You may also be present at the examination by notifying your child's school nurse or the district medical directors office at 286-0787.
- If your child has an appointment for an exam during this school year with their HCP that is after the first 30 days of school, please fill out the attached form to notify the School Nurse.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing the attached consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to your child's school nurse.

Sincerely,

Dr. Jo Silvaroli DNP, FNP
School Medical Director/Nurse Practitioner

Niagara Falls City School District

Health Services

To Be Completed by Parent/Guardian

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your healthcare provider will require this release of information form to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or your school nurse to avoid delays.

I _____ hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child _____ health care providers listed below, pertaining to the health and wellbeing of my child for the _____ School Year. 1. _____ HCP
2. _____ Specialist 3. _____ Specialist.

_____ _____ _____

Parent/Guardian Signature | Parent/guardian printed name | Date

The healthcare provider may disclose the following protected health information.

☐ Immunizations
☐ Health Appraisals (Physical Exam)
☐ Past/Current Medical conditions that may affect Attendance, School Programming, and/or PT, OT, ST needs
☐ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s).

☐ To develop care or therapy plans for routine and emergent school management
☐ To design appropriate educational programs
☐ To assess the impact of the medical condition(s) on school programming and/or attendance
☐ To share school observations/concerns surrounding behavior
☐ To assess a medical basis for modification of transportation and/or home tutoring
☐ Medication delivery and/or therapy prescriptions for PT, OT, ST
☐ At patient's request with no specified purpose
☐ Other _____

Please select one:

☐ This authorization is valid for the entire academic school year 20___ - 20___
☐ This authorization shall expire on ___/___/___ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not valid if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child.

Niagara Falls City School District
Health Services

DENTAL HEALTH CERTIFICATE (To Be Completed by Child's Dental Office)

Parent/guardian: New York State Law (chapter 281) permits schools to **request** a dental examination in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9 & 11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school year, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

SECTION 1. TO BE COMPLETED BY PARENT/GUARDIAN (Please Print)

Child's Name: Last_____ **First** _____**Middle**_____

Birth Date: ____/____/____ **Gender:** __ **Male** __ **Female** **School:** _____ **Grade**_____

Will this be your child's first visit to a dentist? ___**Yes** ___**No**

Have you noticed any problem that interferes with your child's ability to chew, speak or focus on school activities: Yes__**No**__

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.
I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent Signature_____ Date_____

SECTION 2. TO BE COMPLETED BY THE DENTIST

1. **The Dental Health condition of** _____ **on** _____ **(date of exam). The date of exam needs to be within 12 months of the start of the school year in which it is requested. Check one:**

____**Yes, the student listed above is in fit condition of dental health to permit his/her attendance at school.**

____**No, the student listed above is not in a fit condition of dental health to permit his/her attendance at school.**

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities. This may include pain, swelling or infection related to clinical evidence of open cavities. **The designation of "not in fit condition" does not preclude the student from attending school.**

_____ _____
Dentist's Name and address (please print or stamp) Dentist's signature

Optional Sections – If you agree to release this information to your child's school, initial here_____

II. Oral Health Status (check all that apply)

___Yes ___No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated? (A filling, temporary /permanent OR a tooth that is missing because it was extracted as a result of caries or an open cavity.)
___Yes ___No **Untreated Caries** – Does this child have an open cavity? (At least 1/2mm of tooth structure loss at the enamel surface. Brown to Dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on Smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings are considered sound unless cavitated lesion is also present.)
___Yes ___No **Dental Sealants Present**

Other Problems_____

III Treatment Needs: ___No obvious problem. Routine dental care recommended. Visit your dentist regularly.
___ May need dental care. Please schedule an appointment with your dentist as soon as possible
___ Immediate dental care required. Please schedule an appointment with your dentist

F-16D

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ Allergies	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Asthma	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Seizures	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Diabetes	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

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

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				Not Done
Pure Tone Screening	Right ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes	☐

Notes

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

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

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

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

If Restrictions Apply – Complete the information below

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

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

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

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

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

MEDICATIONS

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

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

HEALTHCARE PROVIDER

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

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

OMB Control No. 1810-0021 (Exp. 01/31/2024)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

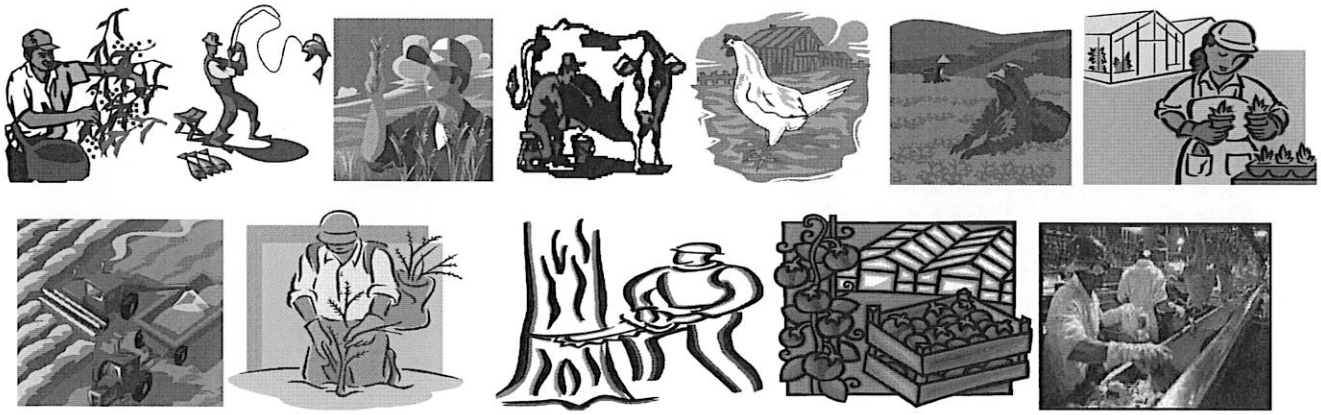
IDENTIFICATION & RECRUITMENT PARENT SURVEY

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

Please take few minutes to complete this questionnaire.

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

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



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

Parent/Guardian Name: _____

Home address: _____

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

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

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

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

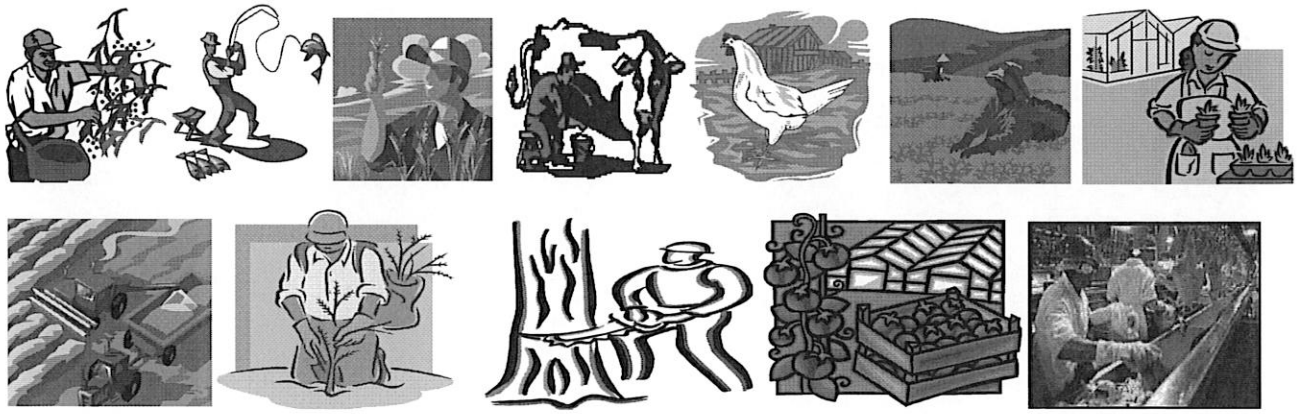
OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

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

Por favor tome unos minutos para completar este cuestionario.

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

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



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

Nombre del Padre/Encargado: _____

Dirección Física: _____

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

Dirección anterior: _____

Nombre del estudiante: _____ Edad_____ Grado_____

Nombre del estudiante: _____ Edad_____ Grado_____

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