CENTRAL SQUARE CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION

Primary Parent/Guardian:

Last First MI

Resident Address:

Mailing Address:

Phone: (H) (Cell) (Work)

Email:

Receives Mail ☐ Can Pick Up ☐ Parental Portal ☐ (Must have a valid email and receive mail regarding the child)

Is ENGLISH the primary language spoken in the home? ☐ Yes ☐ No

If you answered no, complete the NYS Home Language Questionnaire.

If no, what is the primary language spoken in the home?

Spouse or Other Adult in Home:

Last First MI

Resident Address:

Mailing Address:

Telephone: (H) (Cell) (Work)

Email:

Receives Mail ☐ Can Pick Up ☐ Parental Portal ☐ (Must have a valid email and receive mail regarding the child)

LIST BELOW THE CHILD (CHILDREN) YOU ARE CURRENTLY REGISTERING WITH LEGAL NAME AS SHOWN ON BIRTH CERTIFICATE

LAST NAME (**Child No. 1**)	FIRST NAME	MIDDLE NAME	D.O.B.	GENDER
STUDENT ID #:	**SCHOOL:**		**GRADE:**	

Hispanic? ☐ Yes ☐ No

Race? ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

Primary Parent/Guardian is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Spouse or Other Adult in Home is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Does your child currently have an IEP? ☐ Yes ☐ No **Does your child currently have a 504 Plan?** ☐ Yes ☐ No

Does your child have any major medical conditions we should alert the nurse to? ☐ Yes ☐ No

Please note concerns on the health form attached and provide additional information as necessary.

Central Square School District Reentry? ☐ Yes ☐ No **If Yes, school last attended:**

LAST NAME (**Child No. 2**)	FIRST NAME	MIDDLE NAME	D.O.B.	GENDER
STUDENT ID #:	**SCHOOL:**		**GRADE:**	

Hispanic? ☐ Yes ☐ No

Race? ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

Primary Parent/Guardian is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Spouse or Other Adult in Home is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Does your child currently have an IEP? ☐ Yes ☐ No **Does your child currently have a 504 Plan?** ☐ Yes ☐ No

Does your child have any major medical conditions we should alert the nurse to? ☐ Yes ☐ No

Please note concerns on the health form attached and provide additional information as necessary.

Central Square School District Reentry? ☐ Yes ☐ No **If Yes, school last attended:**

CENTRAL SQUARE CENTRAL SCHOOL DISTRICT

LAST NAME (**Child No. 3**)	FIRST NAME	MIDDLE NAME	D.O.B.	GENDER

STUDENT ID #:	**SCHOOL:**	**GRADE:**	

Hispanic? ☐ Yes ☐ No

Race? ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

Primary Parent/Guardian is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Spouse or Other Adult in Home is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Does your child currently have an IEP? ☐ Yes ☐ No **Does your child currently have a 504 Plan?** ☐ Yes ☐ No

Does your child have any major medical conditions we should alert the nurse to? ☐ Yes ☐ No
Please note concerns on the health form attached and provide additional information as necessary.

Central Square School District Reentry? ☐ Yes ☐ No **If Yes, school last attended:**

LAST NAME (**Child No. 4**)	FIRST NAME	MIDDLE NAME	D.O.B.	GENDER

STUDENT ID #:	**SCHOOL:**	**GRADE:**	

Hispanic? ☐ Yes ☐ No

Race? ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

Primary Parent/Guardian is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Spouse or Other Adult in Home is: ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Care ☐ Step Parent

Does your child currently have an IEP? ☐ Yes ☐ No **Does your child currently have a 504 Plan?** ☐ Yes ☐ No

Does your child have any major medical conditions we should alert the nurse to? ☐ Yes ☐ No
Please note concerns on the health form attached and provide additional information as necessary.

Central Square School District Reentry? ☐ Yes ☐ No **If Yes, school last attended:**

Last School District Attended: _____

School Name: _____ **School Address:** _____

Telephone No.: _____ **Fax No.:** _____

I understand that statements made in this form will be relied upon by the Central Square Central School District. I swear/affirm that these statements are true under the penalty of perjury, and I understand that the filing of a false instrument and the theft of services from a government agency such as a school district may be punishable from New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution.

I authorize the release of all information to school personnel (academic, health and confidential) for the student whom I am registering in Central Square Central School District.

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

☐ Birth Certificate ☐ Immunization Records ☐ Custody Papers

☐ Proof of Residency (Required)

☐ Valid NYS Driver's License ☐ Rental Agreement
☐ Utility Bill ☐ Closing Agreement
☐ Other _____

Central Square Central School District

Enrollment Form – Residency Questionnaire

Student Name: _____

Gender: ☐ Male ☐ Female Date of Birth: ___/___/___ Grade: _____

This questionnaire is intended to address the McKinney-Vento Act. By completing this form you are providing residency information that will help to determine the services your child(ren) may be eligible to receive.

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, Legal Guardian **Signature** of Parent, Legal Guardian

_____

Date

Address: _____ Phone: _____

*If the student is **NOT** living in permanent 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 LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.*

CENTRAL SQUARE CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY UPDATE

Name:	DOB:	Grade:	☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Ph:		Date:
	Cell Ph:		

Contact name and number if your child becomes ill or injured during school hours:

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 hospitalized	☐	☐	
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: *(Provide doctor's documentation)*

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

Please be aware that a doctor's order is required for all prescription and over the counter medication given at school.

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ wheelchair ☐ other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ inhaler/nebulizer/peak flow monitoring ☐ 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) _____

_____

NYS law requires a health examination for all students **entering the school district for the first time and when entering Pre-K, K, 1st, 3rd, 5th, 7th, 9th and 11th grade**. Your personal physician or the school physician may do health examines.
Please indicate your preference: ☐ Personal Physician ☐ School Physician

The above information may be shared with appropriate school personnel.

Parent/Guardian Signature: _____ Date: _____

Print Name of Parent/Guardian: _____