SPENCERPORT CENTRAL SCHOOL DISTRICT

REGISTRATION CHECKLIST

☐ **Residency**
To register your child, you must be a resident of the Spencerport School District. Proof of residency is required. Please see next page for list of acceptable documents.

☐ **Proof of Age and Name**
Please provide a certified transcript of a birth certificate or record of baptism when you come to register your child(ren). If these documents are not available, a passport may be used to determine your child(ren)'s age. For more information, please Contact our District Central Registrar at 349-5114.

☐ **Record of Immunization**
We must have each child's complete shot history from your physician or school at the time of registration. For information regarding immunizations, please visit the website under the District tab to find Student Registration.

☐ **Secondary Students (grades 7-12)**
Register as early as possible so that counseling appointments can be scheduled. Bring a copy of the most recent report card/schedule/transcript/IEP to your counseling appointment.

☐ **Physical exam for your child(ren) required**
All students new to the District must have a physical exam within the last 12 months. If your child has not had a physical, you may obtain the *Health Appraisal Form* at the Health Office or from the Spencerport Central Schools Website under the District Tab, Student Registration. The physical does not have to be completed by the time of registration; however, please contact the nurse at the school your child will be attending within two weeks to inform her of the physical date.

☐ **Individualized Education Plan (IEP) or 504 Plan if applicable.**

Questions: If you have any questions, please contact the Central Registration Office at 349-5114.

Required Documents from Parent/Guardians		
☐ Proof of Residency	☐ Proof of Age	☐ Copy of IEP/504 (if applicable)
☐ Complete Address of Last School Attended	☐ Immunization Records	
☐ Custody or Guardianship Papers (if applicable)	☐ Copy of Last Report Card	

SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue
Spencerport, NY 14559

Student(s) may not start school until this form has been checked for completeness and mandated residency, immunization and birth date policy proofs are presented to the Spencerport Central School District.

Student Information

Name: _____
(Last) *(First)* *(Middle)*

Gender: Male Female **Birth Date:** _____

Current Legal Residence:

_____
(Street) *(City)* *(State)* *(Zip)*

Previous Address: _____ **No. of years:** _____
(Street) *(City)* *(State)* *(Zip)*

Home Telephone: _____

Housing Questionnaire
CONFIDENTIAL INFORMATION

YOUR ANSWER WILL HELP SCHOOL STAFF DETERMINE IF THE STUDENT IS ELIGIBLE TO RECEIVE ADDITIONAL SERVICES 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 REORDS, OR BIRTH CERTIFICATE.** STUDENTS WHO ARE PROTECTED UNDER THE McKINNEY-VENTO ACT MAY ALSO BE ENTITLED TO FREE TRANSPORTATION AND OTHER NEEDS.

Where is student(s) currently living? *(Please check one box)*

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

Custody Information

Parents divorced or separated? **Yes** **No**

If yes, name of custodial parent? _____

If there are any restrictions, court documents must be submitted.

Are you the guardian of this child? **Yes** **No**

If yes, please check the box that applies:

☐ **Legal Document** ☐ **Other Document** ☐ **Other Circumstances (explain):** _____

_____

If no, please explain circumstances: _____

_____

Any legal concerns regarding your child that the school should be aware of? Yes No
(Example: Is there any specific person who cannot pick up your child?)

***** Note: District Administration will require additional information if child being registered is not living with either parent.***

Other Children in the Home

Name (Under age 21)	D.O.B.	School Enrolled	Relationship

Other Adults in the Home

Name	Relationship	Work/Cell Phone

School History

Grade Last Attended: _____ Grade(s) Repeated:_____ Present Grade:_____

Date of entry into 9th grade (if applicable): _____

Has your child ever been reviewed by a Committee on Special Education? Yes No

If yes, has your child been receiving Special Education Services? Yes No

If yes, what is your child's classification?_____
Service(s):_____

Has your child ever had a 504 plan? Yes/ No If yes, what is your child's disability?
_____

Accommodation(s) _____

Was the student suspended or expelled from former school? Yes No
Explain:_____
_____

Has the student ever been enrolled in the Spencerport CSD? Yes No

If yes, which building:_____ Date:_____

Name and Address(es) of all schools previously attended: (include any Spencerport schools also)

School Name	Address	Dates Attended	Grades
School Name	Address	Dates Attended	Grades

New Entrant Screening, conducted by Spencerport personnel, is part of the enrollment process. NYS law requires school districts to screen new students who are entering a New York public school. Students may be screened in the areas of math, reading, writing, oral expression and motor skill development. The information from the screening is used to provide input in the correct placement of your student. Your student's building will contact you if further testing is indicated by the screening results. Access to your student's screening results is available upon request.

Parent / Guardian Information

Person registering student: _____

Relationship to Student: ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Foster Parent ☐ Group Home Contact ☐ Legal Guardian ☐Other

Student resides with: Mother Father Guardian Foster Parent Self Other

If other, please specify:_____

Parent / Guardian #1 ***(Note: Parent/Guardian #1 must reside at the same address as student)***
☐ Mr. ☐ Mrs.☐ Ms. ☐ Miss☐ Dr. ☐ Other
Name:

_____
(Last) *(First)* *(MI)*

Address:

_____
(Street) *(City)* *(State)* *(Zip)*

Email:_____
Home Phone #:_____ **Cell Phone #:**_____ **Work Phone #:**_____
Employer:_____
Marital Status: **☐Single ☐Married ☐Separated ☐ Divorce ☐Widowed**

Parent / Guardian #2 ***(Note: Only give address and home phone if different from student)***
☐ Mr. ☐ Mrs.☐ Ms. ☐ Miss☐ Dr. ☐ Other
Name:

_____
(Last) *(First)* *(MI)*

Address:

_____
(Street) *(City)* *(State)* *(Zip)*

Email: _____
Home Phone #:_____ **Cell Phone #:**_____ **Work Phone #:**_____
Employer:_____
Marital Status: **☐Single ☐Married ☐Separated ☐ Divorce ☐Widowed**

Would you like to have a 2nd mailing mailed to parent #2? Yes No

Emergency Contact Information

This person should be able to be contacted in case of illness or emergency with your child at school

Name: _____ Phone #:_____ Cell #:_____

Relationship: _____

Name: _____ Phone #:_____ Cell #:_____

Relationship: _____

SPENCERPORT CENTRAL SCHOOL DISTRICT

Office of the Registrar

71 Lyell Avenue - Spencerport, NY 14559
585-349-5114 Fax: 585-349-5014

INFORMATION REQUEST FORM FOR PREVIOUS SCHOOL (7240F.1)

School Name: _____
School Address: _____
School City, State, Zip: _____
School Telephone: _____
School Fax: _____

Permission is hereby given to Spencerport Central School District to receive information regarding:

Student Name: _____ Birth Date:_____
Grade Last Attended: _____

Please send a copy of the following:

X Transcript / Report Cards
X Test Scores
X Psychological Reports, Speech language, Social History
X Withdrawal Grades
X Individualized Education Plan (IEP) or 504 Plan
X Immunizations and Physical information
X Discipline
X Chapter 53 Screening Results (Gifted)

_____ _____
(Signature of Parent/Guardian) *(Date)*

Mail or Fax to:

_____ Bernabi Elementary School
Attn: Principal
1 Bernabi Road
Spencerport, NY 14559
Fax: 585-349-5466

_____ Canal View Elementary School
Attn: Principal
1 Ranger Road
Spencerport, NY 14559
Fax: 585-349-5766

_____ Munn Elementary School
Attn: Principal
2333 Manitou Road
Spencerport, NY 14559
Fax: 585-349-5566

_____ Terry A. Taylor School
Attn: Principal
399 Ogden Parma Town Line Road
Spencerport, NY 14559
Fax: 585-349-5666

_____ Cosgrove Middle School
Attn: Counseling Office
2749 Spencerport Road
Spencerport, NY 14559
Fax: 585-349-5346

_____ Spencerport High School
Attn: Registrar
2707 Spencerport Road
Spencerport, NY 14559
Fax: 585-349-5280

SPENCERPORT CENTRAL SCHOOL DISTRICT

Notice and Records Request Authorization

NOTICE

Please be advised that the provision of false information on this registration form could result in a perjury prosecution. In addition, the district reserves the rights to recover from parents, legal guardians or other responsible parties the entire actual cost of educating a student, plus related costs, for the entire period that any non-resident student is enrolled in the District's schools without authorization and/or false pretenses. This includes cost for students receiving special education services, which are considerably higher and vary depending upon the specific program(s).

CERTIFICATION

I, _____ the parent/guardian of _____ declare under penalty of perjury that the above named student resides at the address shown on the document indicated above and attached. I will notify the school within two weeks of residency changes and agree to provide a new residency proof and update signed statement at that time. Non-compliance may jeopardize continued enrollment.

FALSIFICATION OF ANY INFORMATION OR DOCUMENT REQUIRED FOR RESIDENCY VERIFICATION OR THE USE OF THE ADDRESS OF ANOTHER PERSON WITHOUT ACTUALLY RESIDING THERE MAY RESULT IN REVOCATION OF STUDENT ENROLLMENT AND POSSIBLE LEGAL ACTION FOR PERJURY.

AUTHORIZATION

I authorize the request of student records from previous school and give permission to the Spencerport Central School District to verify telephone numbers and addresses. I understand that if the District believes that the information on this is form is no longer correct or that the child being registered no longer lives at the address provided by you, the Spencerport Central School District has the right under New York State Law to investigate and to withdraw that child from the Spencerport Central School District.

Parent/Guardian Name: _____ (Please Print)

Parent/Guardian Signature _____ Date: _____

Proofs of Residency for each family registering students is required by the Spencerport Central School District.

Please provide **ONE** item from Category 1 and **THREE** from Category 2. *Please Note: Extra time is provided to you to provide Category 2 documents if you do not have them at the time of registration.*

Category 1:

- ☐ **Homeowner** - Mortgage Statement, Warranty Deed, School or Property Tax Bill - *or-*
- ☐ **Renter** – Lease Agreement, Statement from landlord or other third-party that establishes physical address in District- *or-*
- ☐ **Dual Residency** – Sharing single family home or apartment with another family. *(This section will be completed when the shared housing is not due to loss of residency because of hardship).* Dual Residency Form can be found on our website or upon request from the Central Registrar.

Category 2: *(included but not limited to)*

- Pay Stub
- Utility or other bills
- Income tax form
- Voter registration document
- Membership documents (e.g. library cards) based on residency
- Official driver's license, learner's permit or non-driver identification
- State or other government issued identification
- Documents issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement); or
- Evidence of custody of child, including but not limited to judicial custody orders or guardianship papers

SPENCERPORT CENTRAL SCHOOL DISTRICT

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Spencerport, NY 14559

PHYSICAL EDUCATION FORM FOR NEW STUDENTS
(in district)

Student Name: _____

Grade: _____ **Phone #:** _____ **Date of Birth:** _____

Dear Parent/Guardian:

In order to provide our students with a safe and successful Physical Education experience, it is important that we are aware of any individual medical concerns. With this in mind, please complete the following and return to the nurse's office.

Does your child have, or has he/she ever had:

	NO	YES	If yes, please give details
Allergies			
Asthma (uses an inhaler)			
Seizures or convulsions			
Surgery			
Sustained a head injury (was unconscious)			
Take daily medication			
Heart Condition			
Nonfunctional or absence of eye, ear, kidney, testicle, ovary			
Wears eye glasses or contact lenses			
Uses a hearing aid			
Any medical condition not previously listed			

If no other physical limitations exist, please 'x' the following box: ☐

_____ _____ _____

Date **Signature of Parent/Guardian or Student over the age of 18** **Relationship**

SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue
Spencerport, NY 14559

7513F

Parent and Prescriber's Authorization to Administer Medication in School

Part 1 below is to be completed by family physician.
Part 2 is to be completed by parent or guardian.
Please return by the first day medication is to be given.

Part 1 (Physician please complete)

_____ should receive the medication prescribed by me and described below
(Name of Child)
during school hours.

Name of Medication:

_____

Dosage: _____

Time(s) of administration:

_____

_____

Date to begin medication: _____

Diagnosis: _____

Name of Medication:

_____

Dosage: _____

Time(s) of administration:

_____

_____

Date to begin medication: _____

Diagnosis: _____

_____
Date

_____
Signature of Physician

Part 2 (Parent please complete)

I hereby request the medication described above, prescribed for my child be administered by school personnel as ordered.

Child's name: _____ Physician's Name: _____

Parent/Guardian: _____ Relation to child: _____

Date: _____

* Medication must be in original drug store bottle with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH 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 _____

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension
❒ Other: _____

Allergies: ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Other: _____
❒ Seasonal ❒ Medication: _____

PHYSICAL EXAM

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

				Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	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: cheerlead, 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: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

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. 10/3/07*

SPENCERPORT CENTRAL SCHOOL DISTRICT

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STUDENT HEALTH FORM

Please make necessary changes in **RED**	Student's Legal Name (as appears on birth/adoption certificate)	Gender	DOB	Next School
	Current Address	Student Number	Next Grade	Phone Number

Dear Parent/Guardian:

The purpose of this form is to update your child's school health record. This information is shared on a need-to-know basis with teachers and staff with your signed permission below. In updating this information, we can ensure your child's health in the school setting.

Occasionally, school health personnel will need to speak with your child's health care provider. To do this, we need your signed consent. On the back of this form is a HIPPA compliant consent form. Your signature provides us with your permission to collaborate with your health care providers.

We would appreciate your timely return of this form no later than the first day of school. If there are any questions, or if you need to speak to the school nurse personally, please call the school that your child will be attending.

MEDICAL ALERT/HEALTH CONCERN

_____

_____

_____

_____

CURRENT MEDICATION

Home: _____

School: _____

Emergency Medical Information:

In case your child meets with a serious accident at school and we are unable to contact you, we have your permission to have your child transported to:

_____

Hospital Student's Physician Physician's Phone Number

Give permission for: ___Release to Emergency Contact ___ Transport to Hospital ___Sharing of Confidential Health Information

_____

Date Signature of student (Over 18), Parent or Guardian Relationship

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
(7240F.7)

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

I, _____ authorize my child's healthcare provider(s) listed below
Parent/Guardian's name
to release the medical records of my child, _____ to the district's medical
child's name
officer, physical (PT), occupational (OT), speech therapist (ST), counselor, social worker, psychologist and/or school nurse, or to the service provider(s) listed below.

HC Provider: _____Phone_____FAX_____
HC Provider: _____Phone_____FAX_____
HC Provider: _____Phone_____FAX_____
HC Provider: _____Phone_____FAX_____

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

- ☐ Immunizations
- ☐ Health Appraisals
- ☐ Past/current medical condition and its impact on attendance, school programming, and/or PT, OT, ST needs
- ☐ All records
- ☐ Other (as listed): _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- ☐ To develop care or therapy plans for routine and emergent school management
- ☐ To design appropriate educational programs
- ☐ To assess school observations/concerns surrounding behavior
- ☐ To assess a medical basis for modification of transportation and/or tutoring (home or district-based)
- ☐ 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 as long as my child is enrolled in the district.
- ☐ This authorization is valid for the entire academic school year 20____-20_____
- ☐ This authorization shall expire on _____/_____/ _____ (MM/DD/YYYY)

I acknowledge that I have the right to revoke this authorization at any time by sending written notifications to the Privacy Officer at my healthcare provider's office and to the District Administration Building c/o the Director of Student Services.

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

_____ _____ _____
Date Signature of Parent/Guardian, Patient over 18 Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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

I give permission for my child to receive medication or therapy in school as prescribed by my healthcare provider.

_____ _____ _____
Date Signature of Student (Over 18), Parent or Guardian Relationship