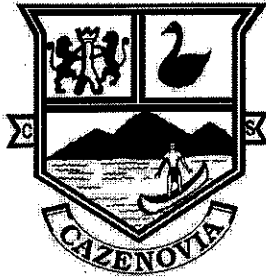


Burton Street Elementary School

37 Burton Street
Cazenovia, NY 13035
315-655-1325 ★ FAX 315-655-1353
Website: www.cazenoviacsd.com

Authorization for Release of Information

According to the Final Regulations - Family Educational Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It states that school officials, including teachers within an educational institution and officials of other schools in school systems in which the students may intend to enroll, may receive a student's records without a written consent of such release.

Name: ______________________ Date: ______________

Date of Birth: ________________ Current Grade: ____________

Current School: ______________________________

Address: ______________________________

School Phone: ________________

School Fax: ________________

Please forward the following records for this student as soon as possible:

- ❑ Report Cards (including most current)
- ❑ Standardized Test Scores
- ❑ Achievement Tests
- ❑ IEP, Special Education/Psychological Evaluation (if applicable)
- ❑ Please release all 504 and IEP records electronically to Cazenovia Central School District
- ❑ Attendance Records
- ❑ Copy of Latest Physical
- ❑ Custodial Concerns (if applicable)

Notes: ______________________________

____

Please send information as soon as possible to:

Debbie Richer
dricher@caz.cnyric.org (preferable method)
FAX: 315-655-1353; *or*
37 Burton Street
Cazenovia, NY 13035

CAZENOVIA SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Student Name: ______________________________ **Preferred Name:** ____________________
Last *First* *Middle*

Gender: ☐ Male ☐ Female **Birth Date:** ____/____/____ **Grade Entering:** ____________

Proof of Age: ☐ Birth Certificate ☐ Other (Specify: Baptismal Certificate, Visa, etc.): ____________________

School Last Attended: ______________________________ **Previous School Phone #:** ____________

Previous School Address: ____
Street *City* *State* *Zip*

Student Information:

Address: ____
Street *City* *State* *Zip*

Mailing Address: ____
Street *City* *State* *Zip*

Telephone #: ____________________ **Town:** ____________________ **County:** ____________

Parent/Guardian Information:

Parent/Guardian #1: ☐ Mother ☐ Father ☐ Step Parent ☐ Foster Parent ☐ Guardian ☐ Other

Name: ______________________________ **Cell Phone #:** ______________________________

Work Phone #: ______________________________ **E-Mail:** ______________________________

Address: ____
Street *City* *State* *Zip*

Parent/Guardian #2: ☐ Mother ☐ Father ☐ Step Parent ☐ Foster Parent ☐ Guardian ☐ Other

Name: ______________________________ **Cell Phone #:** ______________________________

Work Phone #: ______________________________ **E-Mail:** ______________________________

Address: ____
Street *City* *State* *Zip*

Student Resides With: ____

Is there a custody agreement in place for the child: ☐ Yes ☐ No
If yes, which parent or person in parental relation has physical custody? ☐ Mother ☐ Father ☐ Other: ____________
(If yes, please provide the District with a copy of the agreement.)
Can non-custodial parent pick up student? ☐ Yes ☐ No Can non-custodial parent request educational info? ☐ Yes ☐ No
If there is no custody agreement in place, and parents reside at separate addresses, please provide the District with an affidavit acknowledging agreement by both parents as to which parent is designated as parent with residential custody.

Sibling Information: *(Please list each child 0-21 years old)*

Name	Male/Female	Date of Birth	School Attending	Grade Level

CAZENOVIA SCHOOL DISTRICT
* *POST ENROLLMENT INFORMATION* *

Is student a US citizen: ☐ Yes ☐ No **Primary language spoken at home:** ______________________

Place of Birth: ____
City *State* *Country*

If student was not born in the US, from what country did he/she enter the US? ______________ **Date of Entry:** ________

Ethnicity:
Hispanic / Latino / Spanish Origin ☐ Yes ☐ No

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

Has student attended Cazenovia Schools before? ☐ Yes ☐ No **If so, what was the last grade they attended here?** ________

Is the student currently enrolled in any type of support programs/services? ☐ Yes ☐ No
Please check: ☐ Reading Lab ☐ Math Lab ☐ Special Education ☐ Speech/Language ☐ ESOL ☐ Adaptive PE
☐ Occupational Therapy ☐ Physical Therapy ☐ Counseling ☐ Tutoring

Does the student have an IEP (Individualized Education Plan) as determined by a Committee on Special Education? ☐ Yes ☐ No

Does the student have a 504 Plan? ☐ Yes ☐ No

Emergency Contact Information

First Person to Contact (*If parent cannot be reached*):

Name: ______________________ **Relationship:** ______________________

Home Phone: ______________________ **Work Phone:** ______________________

Cell Phone: ______________________ **Which phone number shall we call first?** __________

Second Person to Contact (*If parent cannot be reached*):

Name: ______________________ **Relationship:** ______________________

Home Phone: ______________________ **Work Phone:** ______________________

Cell Phone: ______________________ **Which phone number shall we call first?** __________

Before / After School Care (*If Applicable*):

Name: ______________________ **Home Phone:** ______________________

Cell Phone: ______________________ **Which phone number shall we call first?** __________

Address: ____
Street *City* *State* *Zip*

CAZENOVIA SCHOOL DISTRICT
**** POST ENROLLMENT INFORMATION ****

Health History Information

Student's Full Name: ______________________ **Date of Birth:** ______________________

Mailing Address: ____

Home Phone: ______________________ **Cell Phone:** ______________________

Name of Father/Stepfather/Guardian (*please circle one*): ______________________

Employer: ______________________ **Work Number:** ______________________

Cell Phone: ______________________

Name of Mother/Stepmother/Guardian (*please circle one*): ______________________

Employer: ______________________ **Work Number:** ______________________

Cell Phone: ______________________

Parental Status (*please circle one*): Married Separated Divorced Single

Physician to be called in emergency: ______________________ **Phone:** ______________________

Family Dentist: ______________________ **Phone:** ______________________

Date of Last Physical: ______________________

Has your child ever had any of the following:

____ Ear Infections	____ Hearing or Vision Problems	____ Allergies	____ Measles
____ Mumps	____ Tonsillectomy	____ German Measles	____ Rheumatic Fever
____ Serious Injury	____ Serious Illness	____ Whooping Cough	____ Chickenpox
____ Heart Murmur	____ Taking Daily Medications	____ Birth Defects	____ Seizure Disorder

**** Explanation may be written below or on reverse side of this sheet.***

____

____

Does your child require medication on a regular basis? ☐ Yes ☐ No

If so, does the medication affect his/her behavior? ☐ Yes ☐ No **If yes, how?** ______________________

Does your child have food or other allergies? ______________________

Is there anything concerning the physical, mental, or emotional health of this child that the school should be aware of? ______________________

____

____

Signature of Parent/Guardian: ______________________ **Date:** ______________________

Confidential Health History to be completed by parent: Name ____________________

The health of children greatly influences their ability to learn. Please complete each item below and take this form to your physician at the time of your child's exam.

Has your child EVER had: (Please check, explain and date if yes	No	Yes	Explanation
Allergies (food, medications, hay fever)			
Anemia (low blood iron)			
Arthritis			
Asthma			
Bladder/Kidney problem or injury			
Blood Pressure Problem (High or Low)			
Bee Sting Allergy			
Chicken Pox			
Congenital Defect			
Convulsions/Seizures/Epilepsy			
Diabetes			
Ear Problems/Hearing Loss			
Encephalitis			
Eye Problems/Vision Loss/Glasses/Contacts			
Fainting Spells			
Head Injury/Concussion			
Headaches/Migraines			
Heart Problem/Murmur/Chest Pains			
Hernia			
Injury to the spleen or other organs			
Infectious Mono/Hepatitis			
Fracture-dislocation bones/joints			
Joint sprain/ligament tear/muscle pull			
Loss of a paired organ			
Meningitis			
Menstrual cycle (normal)			
Nose fracture/nose bleeds (frequent or severe)			
Pneumonia			
Rheumatic Fever			
Scarlet Fever			
Stomach Ulcer			
Tuberculosis			
Whooping Cough			
Illness lasting more than one week			
Hospitalized overnight			
Medications on a daily or prn basis at home			
Medications/inhalers during school hours/sports			
Surgery/operation			
Presently under a doctor's care for any reason			

Has any family member under 50 years of age died of a heart problem? Please Explain ____________________

Are there any special problems related to his/her health? ____________________

____

I acknowledge that the above information is correct: ____________________ ____________

Parent Signature Date

CAZENOVIA CENTRAL SCHOOL

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. 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, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / (Month Day Year) | Sex: ☐ Male ☐ Female | Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name | Grade

Have you noticed any problem in the mouth 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's Signature ______________________ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of ______________________ on ______________ (date of exam) The date of the 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 the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

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 including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school 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, please 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 ½ mm 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 a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):______________________

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ______________

Seizures ☐ No	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: ______________ Date of last seizure: ______________

Diabetes ☐ No	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1 ☐ Type 2 ☐ HbA1c results: ____________ Date Drawn: ____________

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: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ______________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: ______________
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL				☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	______________	______________
	______________	______________
	______________	______________
☐ Additional Information Attached	______________	______________

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: ____________________

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

CAZENOVIA SCHOOL DISTRICT
**** POST ENROLLMENT INFORMATION ****

Residency Questionnaire

Name of School: ____

Name of Student: ____
Last *First* *Middle*

Gender: □ Male □ Female **Date of Birth:** ____/____/____ **Grade:** __________ **ID#:** ______________
Month Day Year *(Pre-School – 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 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

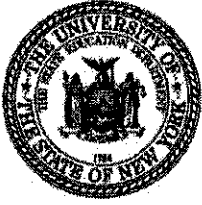
□ Other temporary living situation (Please describe: ______________________________)

□ 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: ____________________



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.)

Question			
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:

CAZENOVIA CENTRAL SCHOOL DISTRICT
POST ENROLLMENT INFORMATION
Cazenovia, New York 13035
Transportation Department 655-1326

NEW STUDENT REGISTRATION
School Year ______________

Today's Date______________________ Date Moving Into District ____________________

Grade _________

STUDENT INFORMATION : **INFORMATION:**
Student Name

Student Name ____
Last First M.I.

Address of Residence: Indicate street or road to assist in locating residence

____
Number Street or Road Name City/Village Home Telephone

Mailing address: (Enter only if different from above)

____
P.O. Box Number or Other Post Office Name Zip

Parent Names (Please give last names if different from student)

____
Father Daytime Telephone

____
Mother Daytime Telephone

Day Care Provider Information: Fill out only if your child will be picked up or dropped off at this location on a regular basis. Example: Working parents using day care.

Name ____

Address ____
House Number Street or Road Name Village Phone Number

Special Requirements: ☐(Check here, explain on reverse)

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES______ NO______

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES_____ NO______

If yes, what farm did you work on?____________ Where? ____________ When?____________

If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name ______________________ D.O.B. __________ Grade________

Child's name ______________________ D.O.B. __________ Grade________

Child's name ______________________ D.O.B. __________ Grade________

Child's name ______________________ D.O.B. __________ Grade________

Parents/ Guardians

Mother's name ____________________ Father's Name ____________________

Home Address ____________________ Home Phone #____________________
(Street Address)

____________________ Work or Message # ______________
(city, town or village) (Zip)

School District ____________________ School Building ____________________

School Contact Person____________________ Contact Number ______________

Other Useful information (directions, farm names, best time to contact, etc.) ______________

____

____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079. Thank you for your assistance.

Herkimer-Fulton-Hamilton-Otsego BOCES
Migrant Education Tutorial & Support Services
Mary Kline, Migrant Education Director

352 Gros Boulevard
Herkimer, NY 13350
315-867-2079

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí ____ NO ______

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? SI_____NO_______

Si UD dijo que si, ¿en que granja? ____________ ¿Donde?____________ ¿Cuándo?____________

Si Usted contestó que SI a AMBOS preguntas de arriba, su familia PUEDA calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a) ________________________ Fecha de Nacimiento__________Grado______
Nombre del niño(a) ________________________ Fecha de Nacimiento __________Grado______
Nombre del niño(a) ________________________ Fecha de Nacimiento __________Grado______
Nombre del niño(a) ________________________ Fecha de Nacimiento __________Grado______

Padres/ Guardianes

Nombre de la Mamá ____________________ Nombre del Papá ________________________

Dirección de la Casa ____________________ Numero de teléfono en casa__________________
(Dirección de la Calle)

____________________ # de teléfono del trabajo o de Mensaje_____________
(Ciudad o Pueblo) (Código Postal)

Distrito escolar ____________________ edificio escolar ________________________

Persona para contactar ____________________ numero para contactar ____________________

Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.) __________

____

____

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a (315) 867-2087 o mandar por correo al dirección de arriba.
Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.

jm 3/23/18

Cazenovia Central School District
Committee on Special Education
Special Education Office
31 Emory Avenue
Cazenovia, NY 13035

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

INTRODUCTION: You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA. Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district can ask you to provide your consent to access your/your child's public benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. If you choose not to provide your consent, or later decide to withdraw your consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

Parental Consent: Beginning on **July 3, 2013**, before your school district can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time. This consent requirement has two parts.

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing [sharing] personally identifiable information about your child (such as your child's name, address, social security number, Individualized Education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the district will (1) identify the records [or information] about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

2. Consent to bill your public insurance program (for example, Medicaid): Your consent must include a statement specifying that you understand and agree that your school district may use your or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

If your school district has on file your consent that you provided before July 3, 2013 to release your child's records and to use your or your child's public benefits or insurance to pay for special education and related services, your school district is required to request a new consent from you only when there is a change in any of the following: the type of services to be provided to your child (for example, physical

therapy or speech therapy), the amount of services to be provided to your child (for example, hours per week lasting for the school year), or the cost of services (that is, the amount charged to the public benefits or insurance program).

If any of these changes occur, your school district must obtain from you a new one-time consent. Before you provide your school district the new, one-time consent, your school district must provide you with this notification. Once you provide this one-time consent, you will not be required to provide your school district with any additional consent in order for it to access your/your child's public benefits or insurance even if your child's services change in the future. However, your school district must continue to provide you with this notification annually.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS: The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for, or enroll in, a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.

3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:

- Decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;
- Cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;
- Increase your premium or lead to the cancellation of your public benefits or insurance; or
- Cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district to use your or your child's public benefits or insurance to pay for special education and related services under IDEA. Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see: **http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parental-consent.html.**

Cazenovia Central School District
Committee on Special Education
Special Education Office
31 Emory Avenue
Cazenovia, NY 13035 (315 655-1361)

Medicaid Consent

Client Identification Number (CIN):___________

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP).

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, ______________________________ as the parent/guardian of, ______________________________

have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Medicaid CIN # ☐☐☐☐☐☐☐☐ **Or Initial here: ________ My Child is NOT Eligible for Medicaid.**

Parent/Guardian Signature: ______________________________

Print Name: ______________________________ Date: ______________