Enrollment/Transfer/Registration

Dear Parent/Guardian:

Welcome to the Duanesburg Central School District! District residents may enroll their children in our schools by contacting the district's PK-12 registrar Joanne Boyd at 518-895-2580 X243. To enroll you must reside in the district. Owning property or a home does not constitute residency. The district does accept tuition students at the state rate.

The attached documents are required to be complete for enrollment. All documents must be completed by the child's legal guardian only.

Thank you for your assistance in providing a smooth transition for your child or children.

AUTHORIZATION FOR ACCESS OF INFORMATION FOR STUDENTS TRANSFERRING TO DUANESBURG CENTRAL SCHOOL DISTRICT
(skip this page if it does not apply to your student)

TO THE PRINCIPAL OF:

SCHOOL:

ADDRESS:

PHONE:

FAX:

NAME	GRADE	BIRTHDATE

I hereby consent that Duanesburg Central School may have access to all records of my child/children, referenced above, (academic, health/immunizations, standardized tests, attendance, psychological/social work, IEP, Section 504, teacher reports, miscellaneous material). Please forward records to Duanesburg Central Schools.

I understand that such records will not be released to other persons without my further consent with the following exception: This form is to be used for the release of school records to colleges, other schools, employers, scholarship or financial aid programs, courts or probation departments and other third parties.

I also understand that according to the Family Educational Rights and Privacy Act Final Rule on Education Records, Federal Register, June 1976, volume 41, number 1118, page 24567 - parental permission is no longer required when records are requested by authorized school personnel.

This information is to be directed to the attention of the following:

Duanesburg Elementary
165 Chadwick Road
Delanson, New York 12053
(518) 895-2580, ext.243
(518) 895-2090 (fax)

Duanesburg Jr./Sr. HS Guidance Office
163 School Drive
Delanson, NY 12053
(518) 895-3000, ext. 227
(518) 895-3090 (fax)

_____

*Signature of Parent/Guardian/Student/School Official / Date
(*Student must be over 18 years of age to give consent.)

Student Enrollment Form

NAME: Last, First (all children in home)	Date of Birth (must submit proof of age*)	Sex	Grade	IEP/504	Parent/Guardian	Student ID (office use only)

***PROOF OF VERIFICATION OF AGE PROVIDED:**

[ ] Birth Certificate;
[ ] Passport;
[ ] Official driver's license;
[ ] State or other government issued identification;
[ ] Military ID card;
[ ] Native American tribal documents;
[ ] Baptismal document

Street Address: (Actual residence NOT PO Box)

_____

_____

Mailing Address: (PO Box Acceptable)

_____

_____

Parent/guardian: _____ **Parent/guardian:** _____
Address: (if different) _____ **Address:** (if different) _____

_____ _____

Telephone: Home: _____ **Telephone:** Home: _____
Work: _____ Work: _____
Cell: _____ Cell: _____

PROOF OF VERIFICATION OF RESIDENCE (3 forms required):

[ ] Copy of Deed;
[ ] Copy of Purchase Contract, with Letter from Attorney (including date/time of closing);
[ ] Lease Agreement or Statement from Landlord, Owner or Tenant from whom you lease;
[ ] Notarized statement from a third party establishing the physical presence of the guardian;
[ ] Pay sub;
[ ] Income tax form;
[ ] Utility or other bills;
[ ] Official driver's license;
[ ] Vehicle registration/vehicle insurance;

CUSTODY: Child's legal custodian is _____ Relationship _____

Child lives with _____ Relationship _____

*Must submit proof of custody

***EVIDENCE OF CUSTODY PROVIDED:**

[ ] Judicial custody orders;
[ ] Guardianship papers;
[ ] Signed affidavits;
[ ] Other: _____

Is there a current order of protection? _____Yes _____No
(If yes, it must be submitted to the building Principal at the time of enrollment)

Is this a foster placement? _____Yes _____No **If yes, name of county** _____
(If yes, copy of DSS 2999 Form required)

☐ Check here if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement

If the box is checked, please complete the STAC-202 form. The answer you give 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.

Does your child presently have an: _____ IEP (Individualized Educational Plan) _____ 504 Plan?

Is there anything you wish to tell us regarding your child, please explain?

Student Emergency Information Sheet

Student Name	
List any life threatening medical conditions (i.e. bee/peanut/tree nut allergy, febrile seizure)	
Custodial Parent(s)	
Home Phone (Custodial)	
Work Phone (Custodial)	
Email	
Noncustodial Parent	
Home Phone (Noncustodial)	
Work Phone (Noncustodial)	
Email	
Emergency Contact Person	
Emergency Contact Phone	

Emergency Dismissal

This plan will only be used in the event that school should close early due to inclement weather or another emergency related situation and you as the parent or guardian, are unable to provide transportation. Please indicate two individuals that your child may be released to in the event of an emergency.

Emergency Contact #1	
Relationship to student	
Phone Number	
Emergency Contact #2	
Relationship to student	
Phone Number	

Grades K-8 CHILD CARE & PARENT TRANSPORTATION Form

STUDENT'S NAME: _____ Bus Route No. _____
Homeroom _____ (leave blank)

Address:_____

Home Phone: _____

Parent Work/Emergency Phone: _____ Cell_____

Parent Work/Emergency Phone: _____ Cell_____

CHILD CARE: Pick up every AM at Child Care Address?: _____ Drop off every PM at Child Care Address?: _____

Provider's full name: _____ Child Care Phone #'s: _____

Address: _____
Bus Route #: _____

PARENT DROP-OFF AM:
I will transport my child to school every day: _____

PARENT PICK-UP PM:
I will transport my child home from school every day: _____

IN AN EMERGENCY:
A. I want my child to go home _____
B. I want my child to go to his/her Care Giver listed above _____
C. Send my child to the home of:
Name _____
Address (specify road and number location):
_____
Phone #: _____ Bus Route_____
_____
_____ My child will be transported to and from school by school transportation from our home.

X Parent/Guardian Signature: _____

Free and Reduced-Price Meals

All children from households meeting income guidelines for the federal Free & Reduced Price Meals Program and whose parents/guardians apply for the program can receive free or reduced-price meals: New York State is covering the $0.25 cost of reduced price breakfast and lunch that was previously paid by the student.

Income guidelines change from year to year. Once approved, children within the household can receive the benefit for the entire school year. Applying is easy and can be done any time during the school year.

Households that receive benefits from the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations, or Temporary Assistance to Needy Families (TANF), can get free meals and should indicate their case number on their application.

Other eligible households must fill out an application each year to be eligible for free and reduced price meals. Return completed applications to DCS' Food Services Director, Luis Fernandez at 163 School Dr., Delanson NY 12053.

2022-2023 Free and Reduced Price Meals Application

If you need help accessing or completing the application, call the DCS Food Services Department at (518) 895-5350, ext. 228, or (518) 895-3000, ext. 228.

Income guidelines (2022-23)

Families whose **gross annual income** is less than the figure listed here may be eligible to receive free or reduced price meals.

- Household of 1: $25,142
- Household of 2: $33,874
- Household of 3: $42,606
- Household of 4: $51,338
- Household of 5: $60,070
- Household of 6: $68,802
- Household of 7: $77,534
- Household of 8: $86,266

For each additional person, add $8,732.

Transportation Form

Residency Address:_____

Other means of identifying home location (i.e. house color, style, mailbox, etc.):_____

Facing your home, neighbor's names on each side and across road, where applicable:

Right:_____ Left:_____ Across:_____

List all children including your UPK child

Complete Name	Grade	Completed by office	Completed by Transportation
		Homeroom	Bus Route & Times

Parent/Guardian(s) Complete Name	Home Phone	Work Phone	Cell Phone

Emergency Dismissal House Owner	
Emergency Dismissal Address	

Bus garage personnel put together bus run routes over the summer. Kindergarten, new transfer students and all students bussed *will be notified by the transportation department the bus route number and pick-up/drop-off times in an August mailing*. Having all child-care information in advance regarding the pick-up and drop-off location is necessary for the transportation department to create a balanced and accurate bus routing system.

Health History

Student Name:	DOB: Age: Grade:	Gender: □ M □ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

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	□	□	
Has had acute illness (Chicken Pox, Scarlet Fever, Measles, Tuberculosis, Mononucleosis, Whooping Cough, Hepatitis, Fifth's Disease, or other)	□	□	□ Illness :_____
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 □ Premature/Concerns at time of Birth

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:

Parent/Guardian Signature: _____
Date: _____

Residency Information

Name of LEA: DUANESBURG CSD

Name of School:

Name of Student: _____ Gender: ☐ Male ☐ Female
Last First Middle

Date of Birth: _____/_____/_____ Grade: _____ ID #: _____
(preschool-12) (school identification number 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 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**. **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.

The University of the State of New York ● The State Education Department ● Office of Bilingual Education

Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank you

TO BE COMPLETED BY SCHOOL PERSONNEL

Please print or type clearly

District: Duanesburg Central Schools

School: (circle one)
CSE out HS MS Elem. Home Schooled

Student Name: _____

Date of Birth: _____ Month _____ Day _____ Year

Student ID # _____

Country of Birth: _____ Ancestry: _____

No. of Years Enrolled
In School, outside the U.S. _____

Name/Position of School
Personnel Completing this Section: A. Conover / JB

Determination: ☐ Possible LEP
☐ English Proficient

==========

(☑ boxes that apply)

1. What language(s) is spoken in the student's home or residence?	☐	**English**	☐	**Other**		
2. What language(s) is spoken most of the time to the student in the home or residence?	☐	**English**	☐	**Other**	specify	
3. What language(s) does the student understand?	☐	**English**	☐	**Other**	specify	
4. What language(s) does the student speak?	☐	**English**	☐	**Other**	specify	
5. What language(s) does the student read?	☐	**English**	☐	**Other**	specify	☐ **Does Not Read**
6. What language(s) does the student write?	☐	**English**	☐	**Other**	specify	☐ **Does Not Write**

7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	**Only a little**	**Not at all**
Understands English	☐	☐	☐
Speaks English	☐	☐	☐
Reads English	☐	☐	☐
Writes English	☐	☐	☐

Student Ethnicity _____

Authorization for Use or Disclosure of Protected Health Information

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

I, _____ authorize my child's healthcare provider(s) listed below:
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____

to release the medical records of my child, _____, DOB _____ to the district's:

❒ Medical Director ❒ School Nurse ❒ Athletic Trainer (AT) ❒ Counselor ❒ Occupational Therapist (OT) ❒ Physical Therapist (PT) ❒ Psychologist ❒ Social Worker ❒ Speech Therapist (ST)

❒ other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)

❒ Immunizations ❒ Health Appraisals ❒ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ❒ Other_____

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

❒ To develop care or therapy plans for routine and emergent school management

❒ To design appropriate educational, school, or athletic 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 or therapy prescriptions

❒ At patient's request with no specified purpose

❒ Other_____

PARENT/GUARDIAN: Please select one.

❒ This authorization is valid for the entire academic school year 20 - 20

❒ This authorization is valid for the duration of attendance within the school district

❒ 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 effective 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 and regulations 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. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____

Signature of Parent/Guardian or student if over 18 Relationship Date

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