



## Central Registration Office

5355 West Taft Road  
North Syracuse, New York 13212

Phone: 315-218-2145

Fax: 315-218-2083

Email: [Registrar@nscsd.org](mailto:Registrar@nscsd.org)

Hours: 8:00am-12n and 1:00pm-4pm

## REGISTRATION CHECKLIST

### Photo Identification of Registering Parent/Guardian:

If you are not the birth parent, proof of custody/legal guardianship will be required.

### Parent's Proof of Residency:

To register your child with the North Syracuse Central School District, you must be a district resident. Proof of residency is required. Provide one of the following:

- Current lease or rental agreement
- Current utility bill (gas, electric, land line phone, cable)
- Recent property/school tax bill, deed, closing document, mortgage statement
- Recent documents issued by government agencies (such as social services)
- If none of the above are available to prove residency, please talk with the registrar. Notarized documentation by the property owner/renter and the parent will be required. Additionally, the parent/guardian must provide sufficient evidence that they have established themselves as a permanent district resident (provide paystub, bank statement, insurance document, or similar item in your name at that address). A general piece of mail is not sufficient to prove residency.

### Proof of Birth Documentation:

Please bring your child's original birth certificate to registration. If that is not available, a passport, immigration card, or certified hospital transcript may be used.

### Child's Physical and Immunization Records:

Recent physical and immunization records are required for new entrants. Obtain a copy of your child's most recent physical and immunization records from your health provider.

### Additional items if applicable:

- High School/Junior HS students – copy of the student's last report card.
- Special Education - Copy of student's IEP or 504 Plan.
- Custody Papers – if applicable
- Foster Children – Provide social worker contact info and Form DSS-2999 from the County Dept. of Social Services.






<b>THIS SECTION FOR OFFICE USE ONLY</b>	Student ID:	School:	Grade Level:
	Date Reg. Complete:	Initials:	<input type="checkbox"/> IEP <input type="checkbox"/> 504 <input type="checkbox"/> ELL <input type="checkbox"/> AIS <input type="checkbox"/> MVA
	Feeder Pattern:	Anticipated Start:	

**North Syracuse Central School District  
STUDENT REGISTRATION FORM**

Proof of Birth Document Shown:  Birth Certificate  Other \_\_\_\_\_

<b>STUDENT:</b> First Name:	Middle Name:	Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Grade Entering:
Country of Birth: <input type="checkbox"/> USA <input type="checkbox"/> Other:	Date of entry into USA (if applicable):	
Student's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other:		
Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native American Indian/Native Alaskan <input type="checkbox"/> Native Hawaiian/Pacific Islander		
Student Home Address:		
Will your child need transportation to and from this <u>HOME</u> address? <input type="checkbox"/> Yes <input type="checkbox"/> No <b><i>If transportation is needed to and from a different address, please complete a transportation request form.</i></b>		

Last School Attended: _____	Grade Level: _____
District: _____	City/State: _____
Is your child currently on disciplinary suspension in the previous school district?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child attended school in the <b>North Syracuse Central School District</b> before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b><i>If yes, school and grade attended here:</i></b> _____	
 Does this child receive any special education services or have an IEP or 504 plan? <b><i>If yes, please provide a copy at registration. Known services:</i></b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
 Does your child have any major medical conditions we should alert the nurse to? <b><i>Please note concerns on the health form attached.</i></b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
 Would you like to complete a free/reduced lunch application?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>OTHER CHILDREN IN HOME:</b>		
Name	Date of Birth	Relationship to Student

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

**PARENTS/LEGAL GUARDIANS MAY PICK UP THEIR CHILD UNLESS WE HAVE DOCUMENTATION (CUSTODY/RESTRAINING ORDERS) ON FILE TO SHOW OTHERWISE.**

*\*Provide a copy of the custody order or temporary guardianship papers if applicable.*

CONTACT 1 (PARENT/LEGAL GUARDIAN)			CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss		<input type="checkbox"/> Can pick up student and receive them from bus. <input type="checkbox"/> Should receive mail <input type="checkbox"/> Give Parent Portal access <i>(must provide an email)</i> <b>Custody Order?*</b> <input type="checkbox"/> None <i>*Cannot be enforced w/out court order</i> <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Visitation <input type="checkbox"/> Temp
Full Name:			
Relationship to student:			
Home Address:			
**Email Address:** REQUIRED to receive info from District			
Home Phone:		Work Phone:	
Cell Phone:		Employer:	

CONTACT 2 (PARENT/LEGAL GUARDIAN)			CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss		<input type="checkbox"/> Can pick up student and receive them from bus. <input type="checkbox"/> Should receive mail <input type="checkbox"/> Give Parent Portal access <i>(must provide an email)</i> <b>Custody Order?*</b> <input type="checkbox"/> None <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Visitation <input type="checkbox"/> Temp
Full Name:			
Relationship to student:			
Home Address:			
Email Address:			
Home Phone:		Work Phone:	
Cell Phone:		Employer:	

ADDITIONAL EMERGENCY CONTACT			CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss		<input type="checkbox"/> Can pick up student and receive them from bus if a parent/guardian is not available.
Full Name:			
Relationship to student:			
Home Phone:		Cell Phone:	

ADDITIONAL EMERGENCY CONTACT			CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss		<input type="checkbox"/> Can pick up student and receive them from bus if a parent/guardian is not available.
Full Name:			
Relationship to student:			
Home Phone:		Cell Phone:	

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NORTH SYRACUSE CENTRAL SCHOOL DISTRICT  
HEALTH RECORD AND HISTORY FORM**

Name:	DOB: Grade:                      Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: <i>(person completing this form)</i>	Home Phone: Cell Phone:	Date:
Physician:	Phone #:	Date of last physical exam:

**I give permission for the above student to have a school physical:**    **YES**    **NO**

<b>Has your child ever:</b>	<b>YES</b>	<b>NO</b>	<b>If YES, please explain and include date:</b>
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies:			<input type="checkbox"/> Food <input type="checkbox"/> Environmental <input type="checkbox"/> Other <input type="checkbox"/> Insect <input type="checkbox"/> Medication
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:			<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Color Blind
Had a hearing problem or condition:			<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Cochlear Implant
Worn dental bridge, braces or mouthpiece			
<b>Have any family members under the age of 50 ever:</b>	<b>YES</b>	<b>NO</b>	<b>If YES, please specify:</b>
Had a heart attack or other serious health Issues			

**CHECK ALL THAT APPLY TO YOUR CHILD:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> GI Conditions (Ulcer, Reflux, IBS)  | <input type="checkbox"/> Scoliosis                       | History of:                                       |
| <input type="checkbox"/> Asthma/Trouble Breathing | <input type="checkbox"/> Headaches/Migraines   | <input type="checkbox"/> Single Organ (Kidney, Testicle) | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Autism/Asperger          | <input type="checkbox"/> Heart Conditions  | <input type="checkbox"/> Skin Condition                  | <input type="checkbox"/> Chicken Pox              |
| <input type="checkbox"/> Dental Injuries          | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Speech Condition                | <input type="checkbox"/> Reoccurring Strep Throat |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Mental Health Condition:<br>(Depression, Eating Disorder,<br>Anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Urinary Condition               | <input type="checkbox"/> Scarlet Fever            |
| <input type="checkbox"/> Ear Infections           |  |  | <input type="checkbox"/> Tuberculosis             |

<b>CURRENT MEDICATIONS</b>	<b>YES</b>	<b>NO</b>	<b>Please list: NAME/DOSE/TIME(S)</b>
Given at School			
Taken at Home			
<b>ASSISTIVE EQUIPMENT at SCHOOL</b>	<b>YES</b>	<b>NO</b>	<b>Please Check All That Apply</b>
During or Outside of School:			<input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other
<b>TREATMENTS</b>	<b>YES</b>	<b>NO</b>	<b>Please Check All That Apply</b>
During or Outside of School			<input type="checkbox"/> Insulin <input type="checkbox"/> Blood Glucose Monitoring <input type="checkbox"/> Inhaler/Nebulizer/Peak Flow Monitoring <input type="checkbox"/> Special Diet

Is there any condition that would prevent your child from participating in physical education or sports?    **YES**    **NO**

Please list any additional concerns: (Use back of sheet if necessary): \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

**North Syracuse Central School District**  
**FOOD ALLERGY AWARENESS INFORMATION**

Does your child have any known food allergies/intolerances?       YES (Continue)       NO (Stop/Sign Form)

**FOOD ALLERGY**

What age was the student diagnosed with an allergy? \_\_\_\_\_

Specific food allergies? \_\_\_\_\_

Pure food, list allergies: \_\_\_\_\_

As an ingredient, list allergies: \_\_\_\_\_

Reaction signs: \_\_\_\_\_

Is medication required? \_\_\_\_\_

Is antihistamine in Nurse's Office? \_\_\_\_\_

Is Epinephrine (Epi-Pen) in Nurse's Office? \_\_\_\_\_

**NON MEDICAL DIETARY RESTRICTIONS:** \_\_\_\_\_

**FOOD INTOLERANCE:**

Pure food, list food intolerance(s): \_\_\_\_\_

As an ingredient, list specific ingredients(s): \_\_\_\_\_

Reaction signs: \_\_\_\_\_

If lactose intolerant, is it:       Milk  
    Yogurt  
    Ice Cream  
    Cheese  
    All types of food or beverages that contain milk

Has the student been hospitalized as a result of an allergic reaction?       YES       NO

If student has **peanut** or **tree-nut** allergy, can student eat anything manufactured in a plant that processes items with peanuts and tree-nuts?       YES       NO

A physician's note must be submitted to the school nurse if you are reporting a food allergy/intolerance for the first time or there has been a change in your child's allergy/intolerance status. A physician's note can be faxed or submitted in person to appropriate school.

Please read the school's Students with Life-threatening Health Conditions (Policy 7521) located on the district website, [www.nscsd.org](http://www.nscsd.org).

Signature indicates agreement to allow the NSCS D to share information on this document with appropriate personnel.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Lisette 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.**

<b>STUDENT NAME:</b>		
_____		
<i>First</i>	<i>Middle</i>	<i>Last</i>
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
_____		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
_____		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
_____		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>
_____	_____	_____

HOME LANGUAGE CODE

_____
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### Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
		<i>specify</i>	
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
		<i>specify</i>	
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
		<i>specify</i>	

### THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
_____	_____
<i>District Name (Number) &amp; School</i>	<i>Address</i>



North Syracuse Central School District  
5355 West Taft Road  
North Syracuse, NY 13212



**Onondaga County Health Department**

Division of Special Children Services  
John H. Mulroy Civic Center - 421 Montgomery Street, Syracuse, NY 13202  
Phone 315.435.3230 - Fax 315.435.2678  
J. Ryan McMahon, II, County Executive  
Kathryn Anderson, MD, PhD, MSPH, Commissioner of Health



Please fill in your and your child's names & sign the bottom of the form even if you DO NOT have MEDICAID. This form will stay in your child's file, and will only be used if/when your child receives special education services.

**Medicaid Consent**

Dear Parent/Guardian:

RE:  
DOB:  
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) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

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

I, \_\_\_\_\_ as the parent/guardian of \_\_\_\_\_,  
*(print name of parent/guardian)* *(please print name of child)*

have received a written notification from the school district/county 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/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or 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/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or 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: \_\_\_\_\_





# NEW YORK STATE MIGRANT EDUCATION PROGRAM

## IDENTIFICATION & RECRUITMENT OFFICE

### 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 answer 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.**

