Central Registration Office
5355 West Taft Road
North Syracuse, New York 13212
Phone: 315-218-2145
Fax: 315-218-2083
Email: 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.

THIS SECTION FOR OFFICE USE ONLY	Student ID:	School:	Grade Level:
	Date Reg. Complete: Initials:	☐ IEP ☐ 504 ☐ ELL ☐ AIS ☐ MVA	
	Feeder Pattern:	Anticipated Start:	

North Syracuse Central School District
STUDENT REGISTRATION FORM

Proof of Birth Document Shown: ☐ Birth Certificate ☐ Other _____

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

Last School Attended: _____ Grade Level: _____

District: _____ City/State: _____

Is your child currently on disciplinary suspension in the previous school district? ☐ Yes ☐ No

Has your child attended school in the **North Syracuse Central School District** before? ☐ Yes ☐ No
If yes, school and grade attended here: _____

Does this child receive any special education services or have an IEP or 504 plan? ☐ Yes ☐ No
If yes, please provide a copy at registration. Known services: _____

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

Would you like to complete a free/reduced lunch application? ☐ Yes ☐ No

OTHER CHILDREN IN HOME:

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:	☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss			____ Can pick up student and receive them from bus. ____ Should receive mail ____ Give Parent Portal access *(must provide an email)* ***Custody Order?**** ____ None **Cannot be enforced w/out court order* ____ Sole ____ Joint ____ Visitation ____ 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:	☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss			____ Can pick up student and receive them from bus. ____ Should receive mail ____ Give Parent Portal access *(must provide an email)* ***Custody Order?**** ____ None ____ Sole ____ Joint ____ Visitation ____ 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:	☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss			____ 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:	☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss			____ 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: □ M □ F
Parent/Guardian: (*person completing this form*)	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***

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, Environment, Insect, Medication or Other*			
Been hospitalized			
Had an operation			
Had an injury requiring an Emergency Room Visit			
Missed 5 days of school in a row due to illness/injury			
Had a bone/muscle injury			
Passed out, had a concussion or serious head injury			
Had a convulsion/seizure			
Had a vision problem or condition: *Glasses, Contacts or Color Blind*			
Had a hearing problem or condition: *Hearing Aid or Cochlear Implant*			
Worn dental bridge, braces or mouthpiece			
Have any family members under the age of 50 ever:	**YES**	**NO**	**If YES, please specify:**
Had a heart attack or other serious health Issues			

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

History of:

- □ Rheumatic Fever
- □ Chicken Pox
- □ Recurring Strep Throat
- □ Scarlet Fever
- □ Tuberculosis

CURRENT MEDICATIONS	**YES**	**NO**	**Please list: NAME/DOSE/TIME(S)**
Given at School			
Taken at Home			
ASSITIVE EQUIPMENT at SCHOOL	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School:			□ Crutches □ Walker □ Wheelchair □ Other
TREATMENTS	**YES**	**NO**	**Please Check All That Apply**
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? □ 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 Student Food Allergies Policy (8101.2) located on the district website, www.nscsd.org.

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

Parent/Guardian Signature: _____ 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:			GENDER:
Month	*Day*	*Year*	❑ 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.)

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:

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

RE:
Dear Parent/Guardian: 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: _____

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: _____North Syracuse Central School District_____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____ /_____ /_____ Grade: _____ ID#: _____
Month Day Year (preschool-12) (optional)

Current Address: _____ Phone: _____

Previous Address: _____

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.** The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

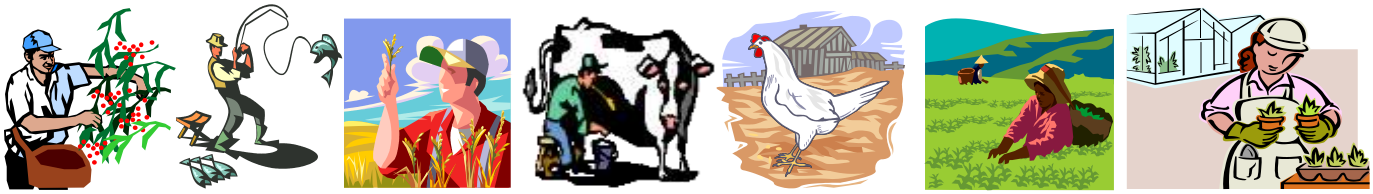
PARENT SURVEY

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.