WAYNE COUNTY

student registration form

To enroll your child for **ANY** services, we will need the following documentation:

- ☐ Birth Certificate or other documentation indicating date of birth
- ☐ Proof of residency (closing papers/lease agreement, current tax bill or current gas/electric bill)
- ☐ Custody papers (if applicable)
- ☐ Immunization history
- ☐ Registration form completed in its entirety

student information

Student Name: ______________________________ ☐ Male ☐ Female
Last First Middle

Preferred Name: ____________________ Date of Birth: ______________ (xx/xx/xxxx)

Address: ____
Street City/Town Zip

Is the student a citizen of the United States? ☐ Yes ☐ No

If the student was not born in the United States, when did the student enter the United States? __________

How many years has the student attended school in the United States? ________

Is this student registering school for the first time? ☐ Yes ☐ No

If no, where did the student last attend school? ______________________________

Is the child hispanic or latino? ☐ Yes ☐ No

What is the child's ethinicity? (Please check one)

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Hispanic
☐ Black, not of Hispanic origin ☐ White, not of hispanic origin

Special services needed: (Please check all that apply)

☐ Current IEP ☐ 504 ☐ ESL (English as a second language)
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech ☐ Other: ____________________

student name: ____________________

guardian/family information

Parent/Guardian 1:

Name: ______________________________

Address: ______________________________

Phone: (home) ____________ (work) ____________ (cell) ____________

Email: ____________ Relationship to child: ____________

I would like to receive mailings for this student:

☐ Yes ☐ No

Has this parent/guardian been employed in temporary or seasonal agricultural work/activities?

☐ Yes ☐ No

Parent/Guardian 2:

Name: ______________________________

Address: ______________________________

Phone: (home) ____________ (work) ____________ (cell) ____________

Email: ____________ Relationship to child: ____________

I would like to receive mailings for this student:

☐ Yes ☐ No

Has this parent/guardian been employed in temporary or seasonal agricultural work/activities?

☐ Yes ☐ No

Student currently resides with: (Court Documents are required for custody rights and legal alerts.)

☐ Both parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: ________

Emergency Contact 1: (Alternate-Parent/Guardians will be contacted first).

Name: ______________________________

Address: ______________________________

Phone: (home) ____________ (work) ____________ (cell) ____________

Email: ____________ Relationship to child: ____________

Allowed to pick child up from school? ☐ Yes ☐ No

student name: ____________

guardian/family information *continued*

Emergency Contact 2: (Alternate-Parent/Guardians will be contacted first)

Name: ____________

Address: ____________

Phone: (home) ____________ (work) ____________ (cell) ____________

Email: ____________ Relationship to child: ____________

Allowed to pick child up from school? ☐ Yes ☐ No

Babysitter/Daycare Provider

Name: ____________

Address: ____________

Phone: (home) ____________ (cell) ____________

When will this child go to daycare? ☐ Before school ☐ After school ☐ Both

Sibling 1:

Name: ____________ ☐ Male ☐ Female D.O.B.: ____________

Relationship to Student: ____________ Grade: ______ School Attending: ____________

Address: (if different from student) ____________

Sibling 2:

Name: ____________ ☐ Male ☐ Female D.O.B.: ____________

Relationship to Student: ____________ Grade: ______ School Attending: ____________

Address: (if different from student) ____________

Sibling 3:

Name: ____________ ☐ Male ☐ Female D.O.B.: ____________

Relationship to Student: ____________ Grade: ______ School Attending: ____________

Address: (if different from student) ____________

Sibling 4:

Name: ____________ ☐ Male ☐ Female D.O.B.: ____________

Relationship to Student: ____________ Grade: ______ School Attending: ____________

Address: (if different from student) ____________

K-12 Student/Parent Computer Use Agreement
Account Request Form

The North Rose Wolcott Central School District uses technology to support 21st century learning. NRWCS is committed to teaching the skills, knowledge, and behaviors students need to be successful and responsible in a technology rich world. Examples of tools utilized (but not limited to) are computers, iPads, iPods, Internet websites, distance learning, blogs, wikis, pod-casts and other online resources that support student learning. The goal in providing Internet access to staff and students is to promote educational excellence by facilitating sharing, innovation, and communication. The use of the Internet and technology resources is a privilege, not a right, and inappropriate use may result in the suspension or cancellation of those privileges.

Technology, for the purpose of this document is defined as: hardware (such as computers and/or mobile devices) software (school authorized and/or online subscriptions) and the network (which provides Internet access, email, and file storage).

Any individual that accesses the NRWCS network on any device (district or personally owned) is bound to the Acceptable Use Agreement.

Computer USE
I understand that the school's computers and Internet access are for instructional purposes and I will use them for school related tasks and activities.

Treatment of Equipment and Resources
I will take care of the schools computer equipment, I will not damage, disable, or interfere with its ability to operate, and I will not download or alter any type software or hardware in any way.
I will use the districts limited resources for instructional purposes and I will not waste them.

Computer and Network Access
I will only access North Rose Wolcott computers that I am assigned to, using the login and password provided to me. I will not give my account information to others to ensure I am sole user of my computer accounts.

Software and Internet Access
I will only use software and Internet websites that are a part of my program of instruction as outlined by my teacher who supports and facilitates my learning.

Internet Safety
I will not give out personal information such as my address, telephone number, parent's work address/ telephone number or the name of my school without my parent's permission.
I will never agree to meet someone I meet online, share a picture of myself or enter into online discussion without my parent's permission

Digital Citizenship
I understand that I have a digital footprint.

I will take care at all times to use positive language and not offend others.

I will not hurt anyone's feelings or bully them using technology.

I will share and publish my own work such as writings, photos, or music. I will give credit to other people's work, and not misrepresent it as my own.

I will take advantage of learning opportunities to become a responsible digital citizen, which is an individual that uses the Internet regularly and effectively, contributing positively to our worlds online environment.

Improper Use
I will notify a teacher or school official immediately of any improper use.

AGREEMENT

I have read the North Rose Wolcott Central School District Technology Usage Agreement, and agree to abide by their provisions.

I understand that my use of the district's technology is not private and that the school district monitors the use of district technology, including but not limited to accessing browser logs, e-mail logs, and any other history of use including on student-owned devices connected to district technology.

I consent to district interception of or access to all communications I send, receive or store using the district's technology resources, pursuant to state and federal law, even if the district's technology resources are accessed remotely.

Student Name (Print Neatly) ____

Signature of Student/Date ____

Graduation Year ____

Home Address: ____

Home Phone Number: ____

As a parent and/or guardian, I will talk with my students about the use of technology and the Internet, and have an ongoing dialogue regarding their experiences.

I recognize that appropriate use of technology is an important skill, and I play a significant role in my child's instructional experience in school and outside of school.

We will establish rules, openly discuss and monitor my child's use of technology to support their learning and to encourage positive relationships with peers.

Topics we will discuss are the appropriate use of technology, how we interact with peers and individuals that we know appropriately, and how we stay safe by not interacting with strangers.

Signature of Parent-Guardian/Date: ____

Home Address: ____

Home Phone: ____

Process:

1. All new accounts are completed at the registrar's office.
2. The registrar's office will provide a copy of the request to the Technology Department.
3. The Technology Department will be responsible for setting up a student account (for MS and HS students) and communicating with the school he/she is registered at the with account information.

2020-21 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses** or **4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses** or **3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses** or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses** or **1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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 ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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 ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ 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	*Required only for students with an IEP receiving Medicaid	

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process **ONLY** **required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : ____________

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

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

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

North Rose-Wolcott Central School District

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:

Birth Date: Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School:

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 him/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit him/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 school, parent 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.

NOTE TO SCHOOLS/LEAS: Please assist students and families fill out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: ______________________________

Name of School: ______________________________

Name of Student: ______________________________
Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: _____ /_____ /_____ (*Month Day Year*)

Grade: _____ (*preschool-12*)

ID#: __________ (*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.** 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.

NOTE TO SCHOOLS/LEAS: If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

Rev. 7/25/08

North Rose-Wolcott Central School District
Student Racial and Ethnic Identification

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School: NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT	
School District Student Identification Number:	Date of Birth (Month/Day/Year): / /
Student Name - Last, First, Middle:	Grade Level:

DIRECTIONS TO PARENT/GUARDIAN
Please answer questions (1) and (2). Please read them before you respond. [For question (2) check (√) the box that best describes your child.] Check (√) only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

   ☐ **YES, Hispanic** ☐ **NO, not Hispanic**

2. Select one or more races from the following five racial groups [For question (2) check (√) all groups that apply to your child; check (√) at least ONE box.]:

   ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition, e.g. Cherokee, Mohawk, Inuit.

   ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the ORIGINAL PEOPLES OF Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ **BLACK:** A person having origins in any of the black racial groups of Africa.

   ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): ____________________

______________________________ Signature of Parent/Guardian/Other

______________ Date

CONFIDENTIAL PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information
To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

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:
			❑ Male ❑ Female
Month	*Day*	*Year*	

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:

NORTH ROSE - WOLCOTT CENTRAL SCHOOL DISTRICT

11631 SALTER-COLVIN ROAD WOLCOTT, NEW YORK 14590 P. 315.594.3141 F. 315.594.2352

Kellie Marciano
Director of Special Education

The North Rose Wolcott Central School District is committed to meeting the needs of students with different learning styles. Referrals to the Committee on Special Education (CSE) can only be made by parents, and requests for referral can be made by teachers, providers, or physicians. The CSE is appointed by the Board of Education to conduct comprehensive evaluations for students who have been referred to the CSE. If the information gathered during the evaluation supports classification according to New York State Education Law, the CSE will then develop an Individualized Educational Plan (IEP) to address the unique learning needs of the student. The Board of Education has also appointed CSE subcommittees on special education to facilitate the meeting process. It is important to note that not all students who are experiencing school difficulties are eligible for special education services.

Once a student is identified with a documented disability by mandated criteria, our special education services provide for the individual needs of the student including academic, social, physical, and management needs. These are provided with the goal of serving the student in the least restrictive environment. In the North Rose Wolcott School District, the first consideration is education of students with disabilities in general education in their home school. There is a percentage of students whose educational needs can only be met in a program operated by Wayne Finger Lakes BOCES.

Preschool age children may also be eligible for special education services, through a similar process overseen by the Committee on Preschool Special Education (CPSE). Educational programs and services for preschool children with disabilities from the ages of three to five are the responsibility of the school district in which the child resides in accordance with New York State Education Law. There is also birth to age two services provided by the county of residence.

The North Rose Wolcott Central School District, in compliance with the Regulations of the Commissioner of Education and Education Law, is required to locate all children with disabilities within its jurisdiction under the age of twenty-one. Children of preschool age and children in all public and private agencies and institutions must be identified, located and evaluated in the district in which they reside. If you suspect your child(ren) ages 3-21, of having a disability and are not receiving special education services, please contact the Director of Special Education at 594-3114.

http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

Kellie Marciano
Director of Special Education and Pupil Personnel Services
Ph.: 315-594-3132 or 315-594-3114
Fax: 315-587-9925

Brandy Starczewski
CPSE & Section 504 Secretary
315-594-3132

Chelsey Palmer
CSE Secretary (Kdg. - age 21)
315-594-3114

North Rose-Wolcott Central School District
Committee on Special Education
11631 Salter-Colvin Road
Wolcott, NY 14590 (315-594-3132)

Medicaid Consent

Dear Parent/Guardian:

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 Plan (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.

Parent/Guardian Signature: ______________________________

Print Name: ______________________________ Date: ______________

***Please provide your child's Medicaid CIN# from their personal Medicaid card:** ______________

(The CIN# is the Alphanumeric ID Number located above the sex and DOB on your child's Medicaid card. It starts with 2 letters, followed by 5 numbers, and ends with 1 letter.)