Registration Checklist – Pre-K to 4th grade:

_____ Birth Certificate (official one with raised seal)

_____ Proof of Residency (driver's license, lease agreement, utility bill, etc.)

_____ Immunization Records

Waverly Central Schools

15 Frederick Street • Waverly, New York 14892-1294
(607) 565-2841 • Fax (607) 565-4997

To: Waverly Central School District Parents/Guardians

From: Mr. Jeffrey DeAngelo, Director of Special Programs

Date: February 19, 2015

New York State law requires school districts to notify every parent, or person in parental relation, of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. If you have a preschool or school-age student (ages 3-21) that you suspect has a disability which affects his or her learning, you may ask the school district to evaluate your child to determine if he or she needs special education services. The Waverly Central School District, like all districts in New York State, operates two teams of specialists that will conduct those evaluations and then make recommendations on your child's abilities and needs. For students aged 3-5, that team is called the Committee on Preschool Special Education (CPSE). For students aged 5-21, the team is called the Committee on Special Education (CSE). I supervise, and facilitate, both teams. You are a key member of both teams.

If you suspect that your child has a disability and you would like to make a written referral to the CPSE or CSE for evaluation, please contact me at 607.565.8101 x 1014 or at jdeangelo@gstboces.org. I will be happy to help you though the process and explain each step.

You may also access a helpful New York State Education Department document called, *Special Education in New York State for Children Ages 3-21: A Parent's Guide.* Go to www.nysed.gov. Under "Quick Links", click on "Special Education". In the search box, enter "Parent's Guide".

Please don't hesitate to contact me if I can be of help.

Waverly Central School District

___ **Lincoln Street Elementary School**, 45 Lincoln Street, Waverly, NY 14892 (607-565-8176)
Grades Pre-K, Kindergarten & 1
___ **Elm Street Elementary School**, 145 Elm Street, Waverly, NY 14892 (607-565-8186) Gr. 2-4
___ **Waverly Intermediate School**, 1 Frederick Street, Waverly NY 14892 (607-565-8101) Gr. 5-6
___ **Waverly Middle School**, 1 Frederick Street, Waverly, NY 14892 (607-565-8101) Gr. 7-8
___ **Waverly High School**, 1 Frederick Street, Waverly, NY 14892 (607-565-8101) Gr. 9-12

Waverly Central School District Registration Checklist

The following documents are needed for enrollment:

_____ Request For Records

_____ Enrollment Form/Residency Questionnaire

_____ Family/Student Information Form

_____ Emergency Contact Form

_____ Student Racial and Ethnic Identification Form

_____ Transportation Request (If needed)

_____ Special Education Transfer/Student Intake Form (if applicable)

_____ Residency Questionnaire

_____ Student Photo

_____ Items from Nurse's Office

Parent/Guardian is responsible to provide the following:

_____ Birth Certificate or equivalent

_____ Immunization Records

_____ Proof of Residency
(Mail at premises, lease/rental agreement, proof of purchase of house)

_____ Proof of Custody (if applicable)

_____ Individualized Education Plan or Section 504 Plan (if applicable)

Waverly Central School District

___ **Lincoln Street Elementary School,** 45 Lincoln Street, Waverly, NY 14892 (607-565-8176)
___ **Elm Street Elementary School,** 145 Elm Street, Waverly, NY 14892 (607-565-8186)
___ **Chemung Elementary School,** 71 North Street, Chemung, NY 14825 (607-529-3221)
___ **Waverly Middle-High School,** 1 Frederick Street, Waverly, NY 14892 (607-565-8101)

Release of Information

Permission is granted to the Waverly Central Schools to obtain information from or release information to the sources listed below for the following children.

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

Please include all educational records, current marks, medical records, psychological reports, IEP data, disciplinary records, etc.

Schools, Agencies or Individuals

Name: _____
_____
_____
Name: _____
_____
_____
Name: _____
_____
_____

_____ _____
Parent or Guardian Date

Send Records to: _____
_____
_____
_____

FAMILY/STUDENT INFORMATION FORM

Parent/Guardian Last Name	First Name	Middle	Salutation	Resident Phone
Spouse/Other Adult Last Name	**First Name**	**Middle**	**Salutation**	**Emergency Phone**
Mailing Address				
Resident Address				

STUDENT(S) PERSONAL ENROLLMENT

Student #	Last Name	First Name	Middle	Sex	DOB	Entry Date	School	Grade	HR

PRESCHOOL CHILDREN? ☐ Yes ☐ No

Last Name	First Name	Middle	Sex	DOB

Waverly Central Schools – Office / Nurse Emergency Information

Child's Name:_____ ☐ Male ☐ Female
Grade _____ Homeroom _____ Date of Birth: _____ Student ID#_____
ADDRESS: Street_____ Town/City_____ State ____ Zip_____
Home Phone _____ Parent/Guardian Cell Phone _____
(*Note: Home Phone and/or Parent/Guardian Cell Phone will be used for contact information in the District's Rapid Notify system.)

Father's (Step) Name _____ Phone _____
ADDRESS: Street_____ Town/City_____ State ____ Zip_____
Place of Employment _____ Work Phone_____

Mother's (Step) Name:_____ Phone _____
ADDRESS: Street_____ Town/City_____ State ____ Zip_____
Place of Employment _____ Work Phone_____
(If parent addresses are different, should mailings be sent to both names listed above ☐ Yes ☐ No)
Name of Parent/Guardian with Whom the Student Resides _____
Home Email Address (Optional) _____

In case there is no one home during the school day, please give us the name(s) of a relative or a reliable neighbor with a telephone whom will come for and take care of your child should he/she become ill during the day.
Name:_____ Relationship:_____ Address:_____ Phone:_____
Name:_____ Relationship:_____ Address:_____ Phone:_____

Please identify any siblings attending school in the district.

Brother(s)	Age	Grade	School	Sister(s)	Age	Grade	School

(Front of Card)_____
(Back of Card)
Does your child have:

1. Allergies to medication/food/environment/bees?_____
2. If allergic to bees, what happens and what is school personnel to do?_____
3. If allergic to any foods, what happens and what is school personnel to do?_____
4. Any illness/injury since last year?_____
5. Any medical conditions (diabetes, seizures, asthma, etc.)?_____
6. Daily medications taken at home (including inhalers):_____
7. In order to keep your child safe while at school, can above information be shared with staff as needed: Yes_____ No_____
8. Does your child have health care insurance?: Yes_____ No_____
9. If no, can an outside agency contact you to help you apply for health care insurance?: Yes_____ No _____

If divorced or separated:

1. Who has custody?_____
2. Are custody papers on file at school?_____
3. Who may pick up the child after school? _____
   _____

Is there any additional information about your child that the school should be aware of (ie: faints easily, frequent colds, etc.)? _____
_____
_____

Excuse Signature Form

The parent or guardian of_____, directs school authorities to accept the name(s) below as authorized signatures for excuses. No other names will be accepted other than those signed below. (Each person must sign his/her own name.)

_____

_____

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

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

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under 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

WAVERLY CENTRAL SCHOOL DISTRICT

SPECIAL EDUCATION TRANSFER/STUDENT INTAKE FORM

Student Name:_____ Parent Name:_____

DOB:_____ Address:_____

Grade:_____ _____

Does the student have a current Individual Education Plan? Yes or No

Does the student have a Section 504 Plan? Yes or No

If so, please provide a copy.

Is the student receiving services from:

Special Education Teacher	Yes or No
Occupational Therapist	Yes or No
Physical Therapist	Yes or No
Speech/Language Pathologist	Yes or No
School Counselor/Social Worker	Yes or No
Nurse	Yes or No

Prior School District:_____

Contact Person:_____

I request that all records be sent to:
Waverly Central School District
Attention: Holly Wright
1 Frederick Street
Waverly, NY 14892

_____ Date: _____
Parent Signature

Parent Phone: _____ Parent E-mail: _____

WAVERLY CENTRAL SCHOOL HC-16

TEMPORARY PLACEMENT AND PERMISSION TO EVALUATE FORM

A. CHILD'S NAME: _____

DATE OF BIRTH: _____

SCHOOL ENROLLING IN: _____

(Lincoln St., Elm St., Intermediate, MS, HS)

GRADE: _____

B. My child has the following handicaps:

_____ 1. Mentally Retarded
_____ 2. Autistic
_____ 3. Emotionally Disturbed
_____ 4. Speech Impaired
_____ 5. Deaf
_____ 6. Hard of Hearing
_____ 7. Visually Impaired
_____ 8. Deaf-Blindness
_____ 9. Orthopedically Impaired
_____ 10. Other Health Impaired
Explain: _____
_____ 11. Multiple Disabled
Explain: _____
_____ 12. Learning Disabled
_____ 13. Traumatic Brain Injury

C. My child received the following services at his/her previous school:

Name of previous School: _____ Phone No.: _____

1. Remedial Reading _____
2. Remedial Math _____
3. Speech Therapy _____
4. Resource Room _____
5. Special Class _____
6. Other _____
Explain: _____

D. I request that the Waverly Central School District provide services similar to what he/she received until the staff has an opportunity to examine my child's records. In addition, I hereby give permission to the Waverly Central School District to evaluate my child in order to secure an appropriate educational program.

_____ _____

Parent's Signature Date

_____

Address

_____

Phone No.

WAVERLY CENTRAL SCHOOL DISTRICT
STUDENT RACIAL AND ETHNIC IDENTIFICATION FORM

Dear Parent/Guardian:

The Waverly Central School District, in accordance with standards set by the U.S. Department of Education regarding the collection and reporting of racial and ethnic data by educational institutions, has adopted a procedure which requires the collection and recording of the ethnic identity of students in the Waverly Central School District. The information collected will be used to:

- ✓ Report information to the State and Federal Education Departments.
- ✓ Plan educational programs and make sure that they are readily available to all students.
- ✓ Study the movement of students in different ethnic groups as they move from school to school.
- ✓ Analyze differences in academic performance, attendance and completion of school.

In order to accomplish this task, we need your help. Please review the Racial/Ethnic definitions below and place a check in the box for the category or categories which best describe your child. The School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a school or district administrator will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Name of School: _____ Grade:_____

Student Name: _____ _____ _____
(Last) (Middle) (First)

" Note: 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."

DIRECTIONS:

PLEASE ANSWER BOTH QUESTIONS 1 AND 2. PLEASE READ BEFORE YOU RESPOND. You must respond to both questions

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 ALASKAN 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.

_____ _____
Signature of Parent/Guardian /Other Date

WAVERLY CENTRAL SCHOOL DISTRICT

Dear Parents/Guardians,

All Students in grades Pre-K, Kindergarten, 1, 3, 5, 7, 9 and 11 are required to have a physical exam. Students who are now to the Waverly School District need to have a physical regardless of grade level within 30 days of entering district. Students who are participants in occupational therapy, physical therapy, speech and resource room are required to have annual physicals. It is recommended that your child's physician perform the physical, as they are familiar with your child's history. If the health office does not receive a completed physical form, or a phone call with an appointment date, your child's physical will be performed at school mid-year. If you have any questions, please contact the health office.

Thank you –

School Nurse's Office

WAVERLY CENTRAL SCHOOL DISTRICT

Student's name: _____

I understand that the information I give to the school nurse is important for the school staff to understand and help the health and education of my child. All information will be kept confidential by the school staff.

Signature of Parent/Guardian: _____

PERMISSION FOR EXAMINATIONS AND SCREENINGS

I give permission for my child to receive physicals and screenings as provided by the school health services of the Waverly School District while he/she is enrolled in the district. I understand NYS law requires:

- Physicals Examinations for grades PK, K, 1, 3, 5, 7, 9 and 11; students in OT, PT, Speech and resource room. All new students to the district at any grade level must have a physical within 30 days of entry to the district.
- Screenings for growth (height and weight) annually
- Vision- all PK, K, 1, 3, 5, 7,11 and any new student to the district
- Hearing-all PreK, K, 1,3,5,7,11 and any new student to the district
- Scoliosis- grades 5-9

I understand that I will be informed, in writing, of any abnormal results of examinations and screenings given to my child.

I give permission for the following: (please circle yes or no)

PHYSICAL EXAMS	YES	NO
SCREENINGS	YES	NO

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

STUDENT INFORMATION

Name of Student _____ Grade _____ DOB_____
Home Address _____ Ph. _____
Current Age _____ Sex ____M ____F School Last Attended_____
Mother/Guardian Name _____ Work # _____
Father/Guardian Name _____ Work # _____
Email address(es) _____
Cell Phone (Mom) _____ Cell Phone (Dad) _____
Student resides with _____ Relationship _____
Physician _____ Physician Phone _____
Hospital _____ Dentist _____

HEALTH CONDITIONS (check all that apply)

	ADD/ADHD		Eating Disorder
	Allergies (Life Threatening)		Endocrine Disease
	Allergies		G.I. Disorder (stomach/intestinal)
	Arthritis/Connective Tissue		Genetic Disorder
	Asthma/Reactive Airway		Headaches Type:_____
	Behavioral/Emotional/Psychological		Hearing Impaired Hearing Aide? Y / N
	Blood Disorder		High Blood Pressure
	Brain/Central Nervous System Disorder		Musculoskeletal Disorder
	Cancer		Prosthesis
	Cardiovascular (Heart/Blood Disease)		Seizure Disorder
	Cerebral Palsy		Skin Disease
	Chicken Pox Date:_____		Spina Bifida
	Cystic Fibrosis		Urinary/Kidney Disease
	Dental		Visually Impaired Glasses? Y / N
	Developmental Delay		Diabetes
	Other (Please List)		

Please fully explain any answers checked above (including severity and symptoms of any allergies)

_____

_____

Please list any medication the student takes on a regular basis _____

Please list any other factors that the school nurse, counselor or your child's teacher(s) should know of which might affect the student's school experience

_____

_____

Severe Allergies

Bee Sting: Yes or No Reaction _____ Treatment _____
Peanut/Nut: Yes or No Reaction _____ Treatment _____
Food: Yes or No Reaction _____ Treatment _____
Medication: Yes or No Reaction _____ Treatment _____
Other Allergies: Yes or No (Please List) _____
Reaction _____ Treatment _____

****Please note: The school DOES NOT provide medications. If your child has a severe allergy that requires an Epi-pen or Benadryl, please send it to school along with a physician's written order and parent/guardian written consent. Please remember to provide the school with the necessary paperwork, as it is required to be on file.****

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

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

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

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

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

Risk Factors for Diabetes or Pre-Diabetes:

Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

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

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

Name:	DOB:

SCREENINGS

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

Recommendations:

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

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

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

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

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

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

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

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

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

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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