WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Registration Packet

Welcome to the Whitehall Central School District!

Please complete this packet and have all required documentation prior to scheduling an appointment with the district regist.

Registration for all children entering the Whitehall Central School District are **by appointment only**. Please call the guidance office at 518-499-0480 to schedule an appointment.

A parent/legal guardian must be present at the time of registration.

PARENTS MUST PROVIDE THE FOLLOWING, ALONG WITH THIS PACKET, TO COMPLETE THE REGISTRATION PROCESS:

- ☐ **Parent/Legal Guardian Photo ID**
- □ **Proof of Age** (any of the following: Birth Certificate, Passport, or Baptismal Certificate)
- □ **Two Proofs of Residency:** A list of acceptable documents can be found on the Proof of Residency Form.
- □ **Proof of Immunizations and a Physical:** must be signed or stamped by a State Licensed health care provider. Proof may be faxed to 518-564-0053 directly from the physician's office.
- □ **Custody Papers** (if applicable)
- ☐ **Individualized Education Plan (if applicable) and Academic Records**.
  All academic records must be received from the previous school before a school schedule can be created. We will request these records from the previous district if you cannot provide copies.

If any of the above documents are unavailable, the school district may consider other forms upon approval.

Once you have registered and all documents have been received, you will be contacted by the appropriate school:

Whitehall Elementary School **99 Buckley Road** **518-499-0330**	**Whitehall Jr.-Sr. High School** **87 Buckley Road** **518-499-1770**
Arrival: 8:20 am **Dismissal: 3:00 pm**	**Arrival: 7:20 am** **Dismissal: 2:00 pm**

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Student Name:_____ **Registration Date:** _____

Parent/Guardian Information

Primary
Parent/Guardian Name:_____ Relationship to Child:_____ **Active Military:** □ Yes □ No

Home Phone:_____ Cell Phone:_____ Work Phone:_____ E-Mail Address: _____

Parent/Guardian Name:_____ Relationship to Child:_____ **Active Military:** □ Yes □ No

Home Phone:_____ Cell Phone:_____ Work Phone:_____ E-Mail Address: _____

Home Address (if different than student's):_____ Receives Mail: □ Yes □ No

Student Resides with: ___Parents ___Mother ___Father ___Foster Parents (Please provide DSS-2999) __Other: _____

Legal Arrangements? □ No □ Yes (please provide court docs) □ Joint Custody □ Sole Custody □ Temporary Custody □ Visitation

Student Information

Student's Name: _____
First *Middle* *Last*

Date of Birth:_____ Age:_____ Grade Level: _____

Gender: □ Male □ Female Home Phone: _____

Residential Address: _____
Street *Apt #/Unit/Floor*

_____
City *State* *Zip*

Mailing Address
(If different than above): _____

Has your child previously attended Whitehall CSD?
□ Yes □ No

Does your child have an IEP (Individualized Education Plan)?
□ Yes □ No

Ethnicity - check those that apply:
□ Hispanic □ Not Hispanic

Race – check those that apply:
□ American Indian or Alaska Native □ Asian
□ Black or African-American □ White
□ Native Hawaiian or other Pacific Islander

Household Information

List all children residing in residence	Gender	Birthdate	Grade	School

---------- Proceed to the Next Page ----------

For Official Use Only:

Documents provided to the District:

□ Photo ID
□ Birth Certificate
□ Immunization Record
□ Physical
□ Dental Certificate

Proof of Residency:
□ Deed/Tax Bill
□ Utility Bill
□ Driver's License
□ Notarized Letter & Home Visit
□ Other _____
□ Signed Lease □ STAC □ Free/Reduced Lunch

Custody Papers:
□ DSS 2999
□ Custody

Student ID #: _____
Grade: _____
Referrals: □ CSE □ ELL
Stamp Date: _____
Registrar Signature: _____

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Emergency Contact

Name:_____ Relationship to Student: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Name:_____ Relationship to Student: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Educational History

Please check any services that your child had at his/her previous school:

Individualized Education Plan (IEP)	□ No	□ Yes	□ Declassified	□ I don't know
Occupational Therapy (OT)	□ No	□ Yes	□ Declassified	□ I don't know
Physical Therapy (PT)	□ No	□ Yes	□ Declassified	□ I don't know
Speech or Language	□ No	□ Yes	□ Declassified	□ I don't know
504 Accommodation Plan	□ No	□ Yes	□ Declassified	□ I don't know
Academic Intervention Services in Math and/or Reading	□ No	□ Yes	□ Declassified	□ I don't know
Alternative Learning Program	□ No	□ Yes	□ Declassified	□ I don't know

Other School Districts Attended ***(list most recent first):***
Please list all previous schools attended, including preschool. If more space is needed, attach additional pages.

School Name	Year(s) of Attendance	Grade	City, State

Photo Release

I hereby grant the Whitehall Central School District the absolute right and permission to use, reuse, copyright, and/or publish original student work, photographic pictures or video footage, which includes/references me and/or my children, in conjunction with an actual or fictitious name. I understand this will be used for the purpose of illustration, promotion, and public relations of school programs and may appear in printed materials, video presentations, news coverage (both print and television) and/or on the district's website.

□ Yes □ No

Please provide the last date your child attended school: _____

PARENT CERTIFICATION AND SIGNATURE

By signing this form, I acknowledge the responsibility of providing the district with accurate information.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

New York State Education Law requires all NEW ENTRANTS and students in Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grades to have a physical exam. The District strongly recommends that your own physician conducts your child's health physical because he/she is most familiar with your child's development. We ask that your physician use the Health Appraisal form provided by the school or their own form and have it at the time of registration or return it to the school nurse of the building your child will attend. **If a physical form from your doctor/pediatrician is not returned within 30 days, your child will have to be examined by the school physician.**

A law was recently enacted that expands health screenings to include dental health of students in New York. The school can provide a certificate for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse.

Thank you for your cooperation with this new requirement. Our students benefit when we work together to promote the health and achievement of all students.

Medical/Health Information

Health History – If your child has had any of the following health problems or disease, please check below.

- ☐ ADD/ADHD
- ☐ Allergies:
  - ☐ Animals
  - ☐ Bees
  - ☐ Food(s): _____
  - ☐ Medication(s): _____
  - ☐ Seasonal
  - ☐ Other
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bone/Joint/Muscle Problems
- ☐ Blood Disorders
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Ear Infections
- ☐ Concussion (date): _____
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Diabetes
- ☐ Hearing Loss
- ☐ Heart Disease or murmur
- ☐ Hepatitis
- ☐ Learning Disability
- ☐ Leukemia
- ☐ Lyme Disease (date): _____
- ☐ Migraines
- ☐ Speech Problems
- ☐ Strep
- ☐ Surgery/Hospitalizations: _____
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Serious Injuries
- ☐ Tuberculosis
- ☐ Vision Problems

Last Vision Exam: _____

Glasses: ☐ Yes ☐ No

Other Health Issues: _____

Comments: _____

Please be aware that ANY medication(s) taken in school requires a written order from a physician and written permission from a parent/guardian. This includes over the counter/non-prescription medication(s).

For the safety and wellbeing of your child, you must be accessible in the event of illness or injury. Notify the school immediately if any of the emergency numbers or contacts you provided change. Parents must pick up their child when he/she is ill or injured. If parents are unable to do so, they must designate a responsible adult to pick up and attend to their child.

Your signature below allows us to share pertinent medical information in written form (name, diagnosis, symptoms of condition, proper treatment and actions for staff to take, if necessary) with school staff. Also, please indicate whether your child will be wearing Medical-Alert Information.

If you have any questions or concerns, please call your child's school Health Office:

Whitehall Elementary: Nicole Molinero – 518-499-0330 ext. 2076

Whitehall Jr.-Sr. High – Carly Pinkowski – 518-499-1770 ext. 2009

_____ _____

Parent/Guardian Signature *Date*

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Authorization for Release of Records/Information

Date of Request: _____

Student Name: _____ **Grade:** _____ **Date of Birth:** _____

School Last Attended: _____

Address: _____

_____

Phone:_____ **Fax:** _____

Signature: _____ **Date:** _____
Parent or Guardian

The above named student has enrolled in our school district. We would appreciate copies of the following records concerning this student:

- ✓ Academic Records (Transcript/report card)
- ✓ Standardized Test scores
- ✓ Discipline Records
- ✓ Attendance Records
- ✓ Health

***All confidential and IEP documentation should be sent to:**
CSE Office: Fax: 518- 564-0053 or Transfer via IEP Direct

- ✓ Individualized Educational Plan (IEP)
- ✓ Psychological

Please provide the following documents via fax to **518-564-0053**, if the box below is checked:

- □ Immunization, Health Records and Birth Certificate

Send Records to:

□ **Whitehall Elementary School** 99 Buckley Road
Whitehall, NY 12887
Phone: 518-499-0330
Fax: 518-704-4728

□ **Whitehall Jr.-Sr. High School** 87 Buckley Road
Whitehall, NY 12887
Phone: 518-499-0480
Fax: 518-704-4728

□ **CSE Office **Special Education****
87 Buckley Road
Whitehall, NY 12887
Phone: 518-499-1771
Fax: 518-564-0053

WHITEHALL CENTRAL SCHOOL DISTRICT
P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Residency Questionnaire

Student Name: _____ Gender: ☐ M ☐ F Date of Birth: _____

Physical Address: _____ City/State/Zip: _____

_____

_____

McKinney-Vento Assistance Act

The answers 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 do not have 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 an emergency or transitional shelter.
- ☐ With another family or other person due to a loss of housing or economic hardship.
- ☐ With an adult who is not a parent or guardian or alone without an adult.
- ☐ In a hotel/motel.
- ☐ In a car, park, bus, train, campsite, public place, abandoned building.
- ☐ Other temporary living situation (Please specify): _____
- ☐ **Student is in permanent housing.**

If a student is in **permanent housing** please sign below and **fill out the Residency Form on the next page**.

If **any of the other boxes were checked**, please sign below and you will need to **fill out a Designation Form (STAC 202)** which the school will provide you.

Print:_____ Signature: _____

Parent/Guardian or Student (unaccompanied youth) Parent/Guardian or Student (unaccompanied youth)

Date:_____

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Residency Form

Parent/Guardian:_____ Student Name:_____ Gr: ____

Relationship to Student(s):_____ Student Name:_____ Gr: ____

Physical Address:_____ Student Name:_____ Gr: ____

City/State/Zip:_____ Student Name:_____ Gr: ____

Please check one: ☐ **Own** ☐ **Rent** ☐ **Reside w/ a district resident**

When you register OR move within the Whitehall Central School District, you are required to provide the school district with Proof of Residency. Post Office Boxes will not be accepted.

You must provide at least two (2) proofs from the following list:

(Your name and address must be indicated on these documents and be current)

If you OWN:	If you RENT:	Reside with a district student:
□ Tax Bill □ House Deed □ Mortgage Statement w/in 30 days □ Current Homeowner's Insurance □ Current Driver's License □ Utility Bill w/in 30 days □ A record of voter registration	□ Documents issued by the federal, state or local agencies. □ Utility Bill w/in 30 days □ Lease agreement (must be signed w/ landlord's name and phone number) □ Current Renter's Insurance	□ Notarized letter from the district resident along w/ the resident's proof of ownership (house deed, tax bill or mortgage statement) A residency check will be done by a school representative as well. District Use Only: Date of Home Visit: _____ ☐ Verified ☐ Not verified

Once this form and documentation are received by the District, residency will be verified.

_____ _____

Parent/Guardian Signature Date

District Use:

_____ _____

Approved By Date

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

STUDENT DIGITAL ACCESS SURVEY

Collecting accurate data regarding digital resource access for New York students will greatly help educators to better serve their students and families. In order to accomplish this, the New York State Education Department is asking parents or guardians to complete a Digital Equity survey (for each student in the family) in grades kindergarten - 12 grade. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, please answer each question below and follow any additional instructions provided for submitting or returning the survey. Thank you for your time and cooperation.

Student Name:_____ Grade:_____

Building: _____

1. Is your child able to access the internet in their primary place of residence? _____Yes or _____No
2. What is the primary type of internet services used in your child's primary place of residence? (please check one)

___ Residential Broadband	___ Cellular	___ Mobile Hotspot
___ Community Wi-Fi	___ Satellite	___ Dial Up
___ DSL	___ Other	___ None

3. In their primary residence, can you child complete the full range of learning activities, including video streaming and assignment uploading, without interruptions caused by slow or poor internet performance? __Yes __ No
4. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

___ Availability ___ Cost ___ Other ___ None

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

PURPOSE: As a parent/guardian you have the right to give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve the School Nurse to obtain records for your child(s) most recent health reports. At times Doctors offices do not send records over when they are asked, for us to be able to obtain them we need to have an authorization form on file. Please fill out the form below with the student(s) primary care physicians office information.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Student name: _____ Date: _____

Student DOB: _____ School District: _____

I hereby authorize the release of records:

From: _____ To: Whitehall Central School
(Name of agency/Person)

_____ 97 & 87 Buckley Road
(Street Address)

_____ Whitehall, NY 12887
(City, State, Zip Code) Fax: 518-704-4728

Description of the records to be disclosed:

_____

_____

_____

_____

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____

Parent/Guardian/Adult student signature Date

WHITEHALL CENTRAL SCHOOL DISTRICT
P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

WHITEHALL CENTRAL SCHOOL DISTRICT
Transportation Form

Please complete Section 1 for your student. Complete Section 2 and 3 only if they apply to your student. This will help us provide accurate information for scheduling your transportations needs to our Transportation Department.
This form must be filled out on an annual basis for each student in your household, or anytime there is a change in your information.

Section 1 Student Information

Student name: _____ Grade: _____ Teacher: _____

Primary Home Address: _____

Parent/Guardian Name: _____ Phone: _____

Mother's Cell Number: _____ Mother's Work Number: _____

Father's Cell Number: _____ Father's Work Number: _____

Section 2 - Daily Circle Pick-Up (Please circle all days that apply)

Please fill out this section only if you have designated days that you will pick up your student

PM Circle Pick-ups: Monday Tuesday Wednesday Thursday Friday

Section 3 List any adults allowed to pick-up your student at Circle pick-up

- _____
- _____
- _____
- _____
- _____

Parent Signature: _____ **Date:**_____

Please return this form on or before the first day of school.

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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: Last First Middle

Birth Date: / / Month Day Year

Sex: € Male € Female

Will this be your child's first oral health assessment? € Yes € No

School: Name

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/ Dental Hygienist

I. The dental health condition of_____ on_____(date of assessment) The date of the assessment 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 his/her attendance at the public schools.

€ No, The student listed above is not in fit condition of dental health to permit his/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/ Dental Hygienist's name and address (please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, 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):_____

II. 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.

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)

Please write clearly when completing this section.

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.

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*

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

HOME LANGUAGE CODE _____

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? _____

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

SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER NYS STUDENT INFORMATIONSSYSTEM :**
District Name (Number) & School Address	

Home Language Questionnaire (HLQ)—Page Three

	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:

Herkimer-Fulton-Hamilton- Otsego
BOCES Migrant Education Tutorial &
Support Services Mary Inline, Migrant
Education Director

352 Gros Boulevard
Herkimer NY 13350
315-867-2079

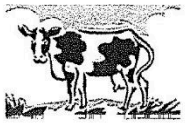
Eligibility Screen for Migrant Education Services

Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES_____NO _____

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES_____NO_____

If yes, what farm did you work one _____ Where?_____**When?** _____




If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name_____D.O.B._____Grade_____

Child's name_____D.O.B._____Grade_____

Child's name_____D.O.B._____Grade_____

Child's name_____D.O.B._____Grade_____

Parents/Guardians

Mother's name _____ Father's Name _____

Home Address _____ Home Phone # _____
(Street Address)

_____ Work or Message # _____
(City, Town or Village) (Zip)

School District_____School Building _____

School Contact Person_____Contact Number _____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. **For** more information, please call the Migrant **Program** at **(315)** 867-2079.
Thank you for your assistance.

WHITEHALL CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age:	Gender: M F
Parent/Guardian: (Person completing this form)	Home Phone: Cell Phone:	Grade: Date:
Doctors Office:	Immunizations up to date: yes no	Date of Last Physical:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies: food environmental insect medication other			Reaction: Medications used for reaction:
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
Had a hearing problem or condition			hearing aid 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			
Had other serious health problems			

CHECK ALL THAT APPLY TO YOUR CHILD:

ADHD
Asthma/trouble breathing
Autism/Asperger
Dental Injuries
Diabetes
Ear Infections

GI Conditions (ulcer, reflux, IBS)
Headaches/migraines
Heart Conditions
High Blood Pressure
Mental Health Condition
(depression, eating disorder, anxiety, OCD, ODD, etc.)
Scoliosis
Single Organ (kidney, testicle)
Skin Condition
Speech Condition
Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school (a doctor's order and parent/guardian consent are needed)			
Taken at home			
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school			crutches walker wheelchair other:

WHITEHALL CENTRAL SCHOOL DISTRICT

TREATMENTS	YES	NO	
During or outside of school			insulin/blood glucose monitoring inhaler/nebulizer/peak flow monitoring special diet Other

Is there any condition that would prevent your child from participating in physical education or sports?
No Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

_____

Parent/Guardian Signature: _____ Date: _____

HUDSON HEADWATERS HEALTH NETWORK

*Please Fill Out ONLY if Your Child Sees a Hudson Headwaters Doctor

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number

Street Address	City	State	Zip Code

A) I hereby authorize records FROM:

Name: Hudson Headwaters

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

B) To be released TO:

Name: Whitehall Schools

Address: 99 Buckley Road

City/State/Zip: Whitehall, NY 12887

Phone: 518-499-0330 Fax: 518-564-0053

C) Information disclosed: *(please select one)*

☑ Medical information ☐ Dental information

☐ Entire record set

☐ Date range: _____ to _____

☐ Other: Physicals, Immunizations, Medications, Information needed for school

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

_____ Alcohol/Drug treatment

_____ HIV/AIDS-related information

_____ Mental health treatment

E) Purpose of requested information: *(please select one)*

☐ At the request of the individual ☐ Transfer of care *(select reason)*

☐ Legal purposes ☐ Patient experience ☐ Other: _____

☑ Coordination of care ☐ Patient relocation

F) Delivery method: *(please select one)*

☐ US mail (Paper) ☐ US mail (CD) ☐ Pick up at: _____

☐ Encrypted email: _____ ☑ Fax to: 518-564-0053

G) Authorization Expiration: Unless previously revoked by me in writing, this authorization will expire on the following date or event: Until Revoked

*Please note: If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:	I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **HIV RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at **(212) 480-2493** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date