

Cambridge Central School District Registration Required Document Checklist

- In order to register your child, the registration packet needs to be completed and ALL the following documents must be submitted.
- Once ALL the forms and documents have been received, the registrar will officially enroll your child, inform the teacher of your child's enrollment and have your child put on their attendance roster.
- The documents listed below must be submitted for official enrollment.

_____ *Copy of your child's birth certificate

_____ * Immunization/Physical records

_____ * Custody Papers (if applicable)

_____ * TWO proofs of residency

- Copy of tax bill/deed to house
- Notarized lease agreement showing physical address in Cambridge school district
- Current electricity/utility/phone bill with Cambridge address
- Pay stub with physical address in Cambridge

Special Education Accommodations:

_____ * Student does NOT have any accommodations.

_____ * Student has an IEP (Individualized Education Plan).

_____ * Student has a 504 Classification.

Cambridge Central School, 24 South Park Street Cambridge, NY 12816

Phone-518-677-8527 ext. 1422

Fax- 518-677-3508

Cambridge Central School District

Achieving Excellence

District Use Only:

Student ID #: _____

Homeroom #: _____ Teacher: _____

Student's Name: _____ Date of Birth: _____ Gender: _____ Grade: _____

Physical Address: _____
Street City County ZIP Code

Mailing Address: _____
(if different than Physical Address) Street or PO Box City County ZIP Code

Phone Number: _____ email address: _____ Language Spoken at Home: _____

Place of Birth _____
City County State ZIP CODE

Ethnicity:

American Indian Hispanic/Latino Asian
 Black/African American Pacific Islander/Native Hawaiian White Other

Special Accommodations: _____ Individualized Education Plan (IEP) _____ 504 Plan _____ No accommodations under IDEA

Parent/Legal Guardian Information:

Parent/Guardian Name: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____ email: _____

Relationship: _____

Physical Address: _____
Street City County ZIP Code

Parent/Guardian Name: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____ email: _____

Relationship: _____

Physical Address: _____
Street City County ZIP Code

Cambridge CSD Registration Form

Order of Protection: yes/no (If an order of protection exists, it must be submitted to the building principal at the time of enrollment.)

Are both parents living at home? yes/no

Who has legal custody: _____ (please provide custody/guardianship papers to the district)

Guardian/Step Parent Name: _____

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

Guardian/Step Parent Name: _____

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

Emergency Contact Information:

1. **Name:** _____ **Relationship:** _____ **Phone Number:** _____

Physical Address: _____
Street City County ZIP Code

2. **Name:** _____ **Relationship:** _____ **Phone Number:** _____

Physical Address: _____
Street City County ZIP Code

3. **Name:** _____ **Relationship:** _____ **Phone Number:** _____

Physical Address: _____
Street City County ZIP Code

Physician to be called in an emergency: _____ **Phone:** _____ **Hospital of Choice** _____

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgement to transport the child to a hospital emergency room and allows school physician to complete physical examinations as required by State Law. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent/Legal Guardian Signature: _____ Date: _____

Cambridge Central School District

Achieving Excellence

Cambridge CSD Health Office Health History Form

Directions: This is a health history form used by the school health staff. Please fill out completely to help inform us of your child's health history. This form is confidential and kept in a secure location within the health services office.

Section 1: Demographic Information

Student's Name: _____ **Date of Birth:** _____ **Gender:** _____

Place of Birth _____
City County State ZIP Code

Parent/Legal Guardian Information:

Parent/Guardian Name: _____

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

Relationship: _____

Physical Address: _____
Street City County ZIP Code

Parent/Guardian Name: _____

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

Relationship: _____

Physical Address: _____
Street City County ZIP Code

Physician to be called in an emergency: _____ **Phone:** _____

Hospital of Choice _____

Section 2: Health History:

Has your child ever had or has the following: (please check if **yes** and **explain** in the next section of this form)

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ever been hospitalized |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Disease/heart murmur |
| <input type="checkbox"/> Allergies (list on the back) | <input type="checkbox"/> Operations |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Ear Problems/Hearing Difficulty | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Other: _____ |

Has your child had any childhood diseases: Chickenpox Other: _____

Section 3: Medication and Medical Services

Does your child take medication on a regular basis? Yes No

If yes – Does your child need to take this medication at school? Yes No

Does your child see a dentist regularly? Yes No

Does your child go for yearly physicals? Yes No

Please explain any boxes checked yes under section 2:

May our school nurses share this information with our staff on a need to know basis? Yes No

Parent Signature: _____ Date: _____

Please list any medications your child takes on a regular basis:

Does your child need to take any of these medications during the school day? Yes No

Section 4: Immunizations and Vaccines

New York State Law requires that all children entering school show proof of having received the following immunizations:

4-5 DPT's

3-4 Polio Vaccines

2 MMR's

3 Hepatitis B Vaccines

2 Varicella Vaccines

As of July 1, 2014, all students entering 6th grade must receive a Tetanus, Diphtheria, and Pertussis Booster (Dtap), second Varicella and fourth polio vaccines.

As of September 1, 2016, all students entering 7th grade and 12th grade must have the Meningococcal Vaccine in order to attend school.

Please provide proof of immunizations with an immunization record. This must be provided at enrollment into the Cambridge Central School District.

HOME LANGUAGE QUESTIONNAIRE

Dear Parent/Guardian:

In order for us to plan an appropriate placement for your child we will need to determine how well he/she speaks, understands, reads and writes English. Your assistance in answering these questions is greatly appreciated.

- | | |
|--|---------------------------|
| 1. What language (s) is spoken in the student's Home? | _____ English _____ Other |
| 2. What language (s) are spoken most of the time in the home? | _____ English _____ Other |
| 3. What language (s) does the student understand? | _____ English _____ Other |
| 4. What language (s) does the student speak? | _____ English _____ Other |
| 5. What language (s) does the student read? | _____ English _____ Other |
| 6. What language (s) does the student write? | _____ English _____ Other |
| 7. In your opinion, how well does the student understand, speak, read and write English? | |

Very Well	Only a little	Not at all
Understand English		
Speaks English		
Reads English		
Writes English		

Signature of Parent/Guardian: _____

Date: _____

**** If a parent/guardian responds in a language other than English for one or more of the questions above, a copy of this form should be forwarded to the building principal.**

FAMILY INFORMATION

Students Name: _____ Date of Birth: _____

Gender: _____ Grade: _____ Date of Entry: _____

Full Name of Siblings	Age	Date of Birth	Grade	Address (if different)

Parent/Legal Guardian Information:

Parent/Guardian Name: _____

Phone Numbers: Home _____ Work _____ Cell _____

Relationship: _____

Physical Address: _____
Street
City
Zip Code

Parent/Guardian Name: _____

Phone Numbers: Home _____ Work _____ Cell _____

Relationship: _____

Physical Address: _____
Street
City
Zip Code

Guardian/Step Parent: _____

Phone Numbers: Home _____ Work _____ Cell _____

Guardian/Step Parent Name: _____

Phone Numbers: Home _____ Work _____ Cell _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: Yes Not Done Hypertension: Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g}/\text{dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:
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SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>

Notes

Hearing Screening: 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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail Referral <input type="checkbox"/> Yes	<input type="checkbox"/>

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

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

***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

Student may participate in all activities without restrictions.

If Restrictions Apply – Complete the information below

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

Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE

Confirmed free of communicable disease during exam

IMMUNIZATIONS

Record Attached Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:

Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Cambridge Central School

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 Dentist's/Dental Hygienist's Signature
(please print or stamp)

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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.

New York State Immunizations Requirements Kindergarten

DTaP 5 doses or 4 with the 4th dose at 4 years of age or older or 3 if starting the series at 7 years of age or older

Polio 4 doses or 3 with the 3rd dose at 4 years of age or older

MMR 2 doses

HepB 3 doses

Varicella 2 doses

A physical exam by your child's physician is required prior to the start of school. The exam needs to be done no more than one year prior to the first day of school.

Thank you for your attention to these matters.

HEALTH OFFICE
CAMBRIDGE CENTRAL SCHOOL
24 SOUTH PARK STREET
CAMBRIDGE, N Y 12816
518-677-8527 EXT.1428
FAX: 518-677-2837

Permission to Administer Over-the-Counter (OTC) Medications at School

The following OTC medications are commonly used for the management of minor acute illnesses and injuries. As the parents and health care provider of _____ we give permission for the school nurse to administer these medications in the following doses, at the indicated intervals, when he/she feels they are indicated by the child's condition, without obtaining further permission.

Acetaminophen: 10-15 mg/kg / dose; every 4 hours for pain or fever, by mouth. Maximum 2 doses/day, 5 doses/ month without further permission.

Ibuprofen: 10 mg/kg / dose, by mouth, every 4-6 hours for pain or fever. Maximum 2 doses/day, 5 doses/month without further permission.

Bacitracin ointment: Use as needed on minor cuts or abrasions

Caladryl: Use as directed on minor rashes, insect bites, etc that cause itching.

Hydrocortizone cream: Use as directed for minor skin irritations.

Diphenhydramine: 1-1.5mg/kg/dose, q6hrs for itchiness, allergic reaction, allergy symptoms. Maximum 2 doses/day, 5 doses /month without further permission.

Maalox/Mylanta: 0.5cc/kg.;dose, q 2-4hours for stomach pain or indigestion. Maximum 2 doses/day, 5 doses without further permission.

Robitussin/Guaifenesin Elixir (100mg/5cc): 5cc q 4 hours under age 12, 10cc q 4 hours if 12 years old or above prn cough.

Parent Signature

Date

Physician Signature

Date

HEALTH OFFICE
CAMBRIDGE CENTRAL SCHOOL
24 SOUTH PARK STREET
CAMBRIDGE, N Y 12816
518-677-8527 ext. 1428

RELEASE TO EXCHANGE CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize you to exchange information regarding _____,
(Student's name)
to include the most recent physical exam and immunization record. Any
information you would like restricted list here: _____

This authorization will be in force and effect in preparation for and throughout your
child's education at Cambridge Central School or until _____.

This authorization may be revoked in writing at any time.

The information may be exchanged between Cambridge Central School Staff and

Physician's Name _____

Address _____

Telephone Number _____

This release has been authorized by:

Signed _____

Relationship _____

Date _____

NOTE TO SCHOOLS/LEAS: Please assist students and families filling 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: ____/____/____ 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

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. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

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

**Cambridge Central School District
Committee on Special Education
24 South Park Street
Cambridge, NY 12816
518-677-8527 Ext. 1419**

Medicaid Consent

2020-2021

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 program (IEP). Please provide us with your child's **Client Identification Number (CIN)**, which can be found on the left hand side of the card. The CIN number begins with two letters followed by five numbers and ends with a letter. This identification number is needed for Cambridge Central School to bill Medicaid for services.

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 _____ CIN # _____, 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: _____



schooltool.

CAMBRIDGE CENTRAL SCHOOL DISTRICT PARENT / GUARDIAN ACCESS REQUEST FORM

The Cambridge Central School District can provide access to student information via the SchoolTool link off of our home page. In order to protect the confidentiality of student records, all parents/guardians who want to use this service are required to fill out this form and return it in person to the registrar's office. For security purposes, a photo ID is required when you return the form. If you are unable to bring the form in, you may also choose to have the form notarized and sent to: Parent Portal Registration
ATTN: Steve Butz, Cambridge Central School, 24 South Park Street, Cambridge, NY 12816.

Please Print

Parent/Guardian

Name: (One per form) _____
(First name, Middle Initial, Last Name)

Parent/Guardian

Home Address: _____

Parent Guardian Email Address (**REQUIRED**): _____

ONLY ONE EMAIL ADDRESS PER APPLICATION – Please print email address neatly; this will be your user name

Please list all the children in the household who are/will be enrolled @ Cambridge (Student Name)	Your relationship to student	Reside with student (Yes or No)	School	Grade

I certify that all the above information is true and I have legal authority to access the records of the student(s) listed above.

Signed: _____
Signature and ID must be of that Parent/Guardian shown on the first line

Date: _____
(mm/dd/yy)

Important: Once the information provided above is verified and processed, you will receive notification via email that your account has been created and instructions on how to get an initial password. When you receive your password, you will be able to access SchoolTool through our website: <http://www.cambridgecsd.org>, and change your password. Your user name is your email address. Your password should be alphanumeric, containing at least eight characters, two of which must be numeric, i.e. "yankee07", and at least one capital letter.

Office Use Only:	Date: _____	ID Verified	Form & ID Checked By: _____ (First initial, last name)
District Technology:	Verify Email	Account Created	Date: _____ Initials: _____

Notary Statement (if applicable):

STATE OF: _____ COUNTY OF: _____

On this day personally appeared before me _____ to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed. Witness my hand and official seal hereto affixed this _____ day of _____, _____, Notary Public for the State of _____, Commission expires _____.

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.

MODEL ENROLLMENT FORM - RESIDENCY 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

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.

ATENCIÓN ESCUELAS Y DISTRITOS: Ofrezca asistencia a los estudiantes y familias para completar este formulario. No incluya este formulario en el paquete de inscripción sin advertencias apropiadas. Por ejemplo, tendrá que cambiar partes del paquete de inscripción que requieren que se entreguen prueba de inscripción antes de matricular. Estudiantes elegibles según el Acto de McKinney-Vento, no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

FORMULARIO DE INSCRIPCIÓN – CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____

Apellido

Primer Nombre

Segundo Nombre

Género: Hombre
 Mujer

Fecha de Nacimiento: ____ / ____ / ____
Mes Día Año

Grado: ____ ID#: ____
(jardín de infantes – 12) (opcional)

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Dónde está el estudiante viviendo actualmente? (Por favor marque una caja.)

- En un refugio
- Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- En un hotel/motel
- En un carro, parque, autobús, tren, o camping
- Otra vivienda temporal (Por favor describa): _____
- En un hogar permanente

Nombre de Padre, Guardián, o
Estudiante (para jóvenes sin acompañamiento)

Firma de Padre, Guardián, o
Estudiante (para jóvenes sin acompañamiento)

Fecha

Si el estudiante **NO** vive en un hogar permanente, no se requieren prueba de domicilio u otros documentos normalmente requeridos para inscripción y el estudiante debe ser matriculado inmediatamente. El enlace del distrito debe ayudar al estudiante conseguir los documentos necesarios, como documentos de inmunización o documentos escolares después de que el estudiante sea matriculado.

ATENCIÓN ESCUELAS Y DISTRITOS: Si el estudiante **NO** vive en un hogar permanente, favor de asegurarse que una Formulario de Designación sea completado.