Cambridge Central School District
Registration Required Document Checklist

- **In order to register your child, the entire registration packet needs to be completed and all the following documents must be submitted**
- Once all forms and documents have been received, the guidance department will create a schedule, inform the teachers of your child's upcoming arrival and have your child on their rosters.

_____ * Copy of your child's birth certificate - Signature rec'd _____

_____ * Immunization/physical records - Signature rec'd _____

_____ * Custody Papers (if applicable) - Signature rec'd _____

_____ * Two proofs of residency - Signature rec'd _____

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

Special Education Accommodations

_____ * Student does not have any accommodations. Signature _____

_____ * Student has an IEP (Individualized Education Plan) Signature rec'd _____

_____ * Student has a 504 Classification - Signature rec'd _____

Cambridge Central School, 24 South Park Street Cambridge, NY 12816
Phone - 518-677-8527 ext. 1416
Fax - 518-677-3031

CAMBRIDGE CENTRAL SCHOOL DISTRICT STUDENT DATA FORM

For Office Use Only

❒ New Student
❒ Re-Entry

Effective Date: _____
Teacher: _____
1st Year Entered 9th Grade: _____

Bus #: _____
Services: _____
_____

Student Information

Student's Last Name First MI	Grade	Sex	Birth Date (mm / dd / yyyy)	City of Birth	State or Country of Birth

Residence Address City/State/Zip	Home Phone	**Students Born Outside the United States**	
		# of years in US Schools	
Mailing Address (If different from residence address) City/State/Zip	Emergency Phone	Home Language Spoken	

Parent / Guardian Information

Relation	Address (If different from student address)	Cell Phone	Employer Name & Phone	E-mail Address	CHECK ANY THAT APPLY: Reside w/ student	Receive Mailings	May pick up Student
Father's Name							
Mother's Name							
Step Father's Name							
Step Mother's Name							
Legal Guardian's Name							

Before/After School
Child Care Provider: Address: Phone:

CUSTODY LIMITATIONS: (must be documented with legal papers in district folder) Notes:
Limitations ❒ Yes ❒ No Legal papers filed in district folder ❒ Yes ❒ No

Previous School Attended:
Name_____
Address_____
_____

Name of Guidance Counselor or Principal at Previous School:
_____
Date last attended classes at previous school_____
Has the student ever attended Cambridge? ❒ Yes ❒ No _____

Ethnicity: Please indicate ethnicity. If you choose not to enter this information, NYS requires the district to choose.

Hispanic: ❒Yes ❒ No

Primary Ethnic Code Check one (If Hispanic you may indicate additional)
❒ White ❒ Native Hawaiian/Pacific Islander ❒ Asian
❒ American Indian/Native Alaskan ❒ Black/African American

Additional Race/Ethnicities: (Check all that apply)
❒ White ❒ Native Hawaiian/Pacific Islander ❒ Asian
❒ American Indian/Native Alaskan ❒ Black/African American

Continued on Next Page ⇨

List brothers and sisters that are part of the family unit:

Name	Date of Birth	Sex	Grade	Name	Date of Birth	Sex	Grade

Other than parent, in case of emergency, who can we call:

					CHECK ANY THAT APPLY		
Name	Relationship	Home Phone	Cell Phone	Work Phone	Reside w/ student	Request Mailings	May pick up student

Languages, other than English, spoken at home (specify)_____

Has the student ever been retained? ❒ Yes ❒ No Grade(s)_____

Is the student receiving any support services in any areas? ❒ Yes ❒No

If yes, description_____

Armed Forces: Is parent/guardian currently on **active duty** with the armed forces? Yes or No

If yes, please provide the entry date in armed forces _____
Active duty means full time duty in an active military serve of the U.S. (Army, Navy, Air Force, Marines, Coast Guard, and National Guard)

Does the student have a 504 Plan on file with the previous district? ❒ Yes ❒ No Does the student have an IEP on file with the previous district? ❒ Yes ❒ No

If you would like to identify the student as physically disabled, please check here ⇨ ❒

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, immuz. records, or birth cert. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Living Arrangements: Are you living in a shelter; with relatives or others due to lack of housing; in an abandoned apartment/building, in a motel/hotel, camping ground, car, train/bus station or other similar situation due to the lack of alternative, adequate housing; or temporarily housed in a shelter awaiting an Office of Children and Family Services permanent foster care placement?

❒ Yes ❒ No

Activity Permission: I give my permission for this student to participate in any activity of the Cambridge Central School District, such as field trips, pictures, etc. during the school year if under school supervision.

❒ Yes ❒ No

_____ _____ _____

Parent/Guardian PRINT NAME Parent/Guardian SIGNATURE Date

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

Medicaid Consent

Dear Parent/Guardian:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education 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: _____

2024-25 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

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

NEW YORK STATE | Department of Health

CAMBRIDGE CENTRAL STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

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
Been hospitalization	☐	☐	
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	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

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

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

_____

Parent/Guardian Signature: _____ Date: _____

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: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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

BMI_____kg/m2

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

Hyperlipidemia: ☐ 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	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ 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

(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.

(3/2018)

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 _____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
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:**
		❑ Male ❑ Female
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE _____

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	_____ *specify*	
2. What was the first language your child learned?	❑ English	❑ Other	_____ *specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 _____ *specify*		❑ Parent 2 _____ *specify*	
	❑ Guardian(s) _____ *specify*			
4. What language(s) does your child understand?	❑ English	❑ Other	_____ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	_____ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	_____ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	_____ *specify*	❑ Does not write

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

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

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes ***No*** ***Not sure***
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. *If referred for an evaluation, has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:_____

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ Parent ❑ 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:

Cambridge Central School

Digital Equity

Collecting accurate data regarding digital resources 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 - Grade 12. 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? Y or N

2. What is the primary type of internet service used in your child's primary place of residence?

   ____ Residential Broadband ____ Cellular ____ Mobile Hotspot

   ____Community WIFI ____ Dial Up ____DSL ____None

   Other: _____

3. In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance? Y or N

4. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

   ____Availibility ____Cost ____None Other: _____

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. 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.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female ☐ Non-binary

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

Grade: ____ (*preschool-12*)

ID#: _____ (*optional*)

Address: _____

Phone: _____

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

Where is the student currently living? (*Please check **one** box.*)

☐ In a shelter
☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
☐ In a hotel/motel
☐ In a car, park, bus, train, or campsite
☐ Other temporary living situation (Please describe): _____
☐ In permanent housing

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Date

If **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases, **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.

<u>ATENCIÓN ESCUELAS Y DISTRITOS</u>: Ofrezca asistencia a los estudiantes y familias para completar este formulario. Este formulario debería de ser incluido como la primera página de los materiales de inscripción que el distrito comparte con familias. 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 la Ley McKinney-Vento, no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer ☐

Fecha de Nacimiento: _____ / _____ / _____ Grado:_____ ID#: _____
Mes Día Año (jardín de infantes – 12) (opciónal)

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según la Ley 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 la Ley McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (*Por favor marque **<u>una</u>** 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 CUALQUIER caja que no sea "En un hogar permanente" está marcada, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

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

NYSPHSAA TRANSFER NOTIFICATION

This form must be completed for all transfer students requesting a waiver or exemption

THE STUDENT CANNOT PARTICIPATE IN A CONTEST/SCRIMMAGE UNTIL APPROVED BY THE SECTION.

Please check one: **(Required supporting documentation must be attached)**

Waiver Request

☐ ***Health & Safety:*** Appeals are considered for safety, mental health, personal relationships and other similar circumstances. Written documentation is required from Superintendent of Schools or High School Principal of the sending school indicating the specific circumstances which necessitated the transfer. Supporting documentation from a third party outside of the school may be submitted (ex. police report).

☐ ***District of Residency:*** (No change of residence. School registration change only.) Student is returning to a school within the district boundaries of his/her residence.

☐ ***Hardship:*** Each school shall have the opportunity to petition the section involved to approve transfer without penalty based on an undue hardship for the student. Educational Waivers will not be considered as an undue hardship.

☐ ***Financial:*** Requires documented proof of a significant loss of income or a significant increase in expenses.

Exemption Request

☐ ***Divorced/Legally Separated Parents:*** A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six months. The legal separation agreement must address custody, child support, spouses support and distribution of assets and be filed with the County Clerk or issued by a Judge.

☐ ***Homeless:*** Student declared homeless by the Superintendent under McKinney-Vento Legislation [NYSED 100.2].

☐ ***Other:*** Exemptions (*six*) as denoted in NYSPHSAA Rule #31 (Transfer). Exemption: _____

Residency Change

☐ *NYSPHSAA transfer/residency policy states: (A residency is changed when one is abandoned and another one established through action and intent. Residency requires one's physical presence as an inhabitant and the intent to remain indefinitely. The mere renting of property within the District does not confer residency.* ***The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA regulations.***

By signing this document, I attest the information provided is accurate and correct; I have understanding the falsification of information could lead to ineligibility; the immediate family will be physically residing at the current address as inhabitants and intend to remain indefinitely; the student has transferred without inducement or recruitment.

Parent Signature: _____ Name (Print): _____ Date: _____

PART ONE

TO BE COMPLETED BY STUDENT'S RECEIVING SCHOOL

Receiving School: _____ Student's Name: _____

Date of Transfer: _____ Date of Birth: _____ Grade Level: _____ Date Entered 9th Grade: _____

Student/Family Previous Address: _____

Student/Family Present Address: _____

Parent's Names and Current Address(es)

(Parent I name & address): _____

(Parent II name & address): _____

Name of Sending School _____ Did student participate in athletics at sending school? Yes ☐ No ☐

The receiving school's administration is responsible for abiding by all NYSPHSAA Eligibility standards.

Athletic Director's signature: _____ Date _____

Principal's signature: _____ Date _____

Superintendent's signature: _____ Date _____

**** DO NOT COMPLETE BELOW - SECTION USE ONLY ****

SECTION APPROVAL: _____ **SECTION EXECUTIVE DIRECTOR: _____**

SECTION DENIAL: _____ **DATE: _____**

NYSPHSAA TRANSFER NOTIFICATION

This form must be completed for all transfer students requesting a waiver or exemption

PART TWO

TO BE COMPLETED **BY SCHOOL STUDENT PREVIOUSLY ATTENDED**
AND RETURNED TO STUDENT'S PRESENT SCHOOL

Name of Student: _____ Date entered 9th grade _____

Did student repeat any grades? _____ If yes, which grade(s)? _____

Name of School(s) Attended Prior to Transfer _____

Date of entrance to this school _____ Date of withdrawal from this school _____

Student's address while attending the above school _____

With whom did student reside at this address (name)? _____

Relationship of this (these) person(s)?_____

PART THREE

TRANSFER STUDENT SPORT HISTORY

(Please include all sports student participated)

	YEAR	SPORT	LEVEL	SCHOOL
7th Grade	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
8th Grade	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
9th Grade	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
10th Grade	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
11th Grade	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
12th Grade	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____
	_____	_____	V ☐ JV ☐ FR ☐ MOD ☐	_____

The undersigned has no knowledge the student named has transferred to his/her present school without inducement or recruitment.

Athletic Director's signature: _____ Date _____

Principal's signature: _____ Date _____

Superintendent's signature: _____ Date _____

revised: 7/30/2024