FALCONER CENTRAL SCHOOL DISTRICT
FALCONER, NEW YORK
CONFIDENTIAL ENROLLMENT INFORMATION FORM

Office Use Only – E-mail Notice Sent To:
☐Main Office ☐Computer Tech.
☐Bus Garage ☐Psychologist/CSE
☐Health Office ☐Team/Grade Level
☐Special Education ☐Media Center 7/2008

Effective Date _____ / _____ / _____ ☐Enter ☐Re-Enter ☐Transfer Out ☐Grade Level Change ☐Information Change

Has student EVER attended a Falconer District School? ☐No ☐Yes If yes, what year(s)? _____ **FamilyID** _____

Name of Student _____ ☐ Male ☐ Female **POWERSCHOOL ID #** _____ **Gr 9 Cohort Year** _____

Name of School Entering _____ **Grade** _____ (PreK-12)

Date of Birth _____ / _____ / _____ **Birth Place** _____ City/State/Country

Social Security # _____

Physical Address _____ (Street Address) (PO Box #)
_____ (City) (State) (Zip)

Home Telephone _____

Hispanic: ☐ Yes ☐ No
Ethnic Origin: White/Black/Native/Asian

Mailing Address *(IF DIFFERENT FROM PHYSICAL ADDRESS)*
_____ (Street Address) (PO Box #)
_____ (City) (State) (Zip)

Language Spoken in Home: Eng/Span/Other____

Are you able to receive non-emergency calls at work?
☐ Yes ☐ No

Name of School Last Attended _____ (School Name) (City) (State)

Does someone get a second mailing of student information? ☐ Yes ☐ No

E-Mail Addresses **Home:** _____
Work: _____

Name _____
Mailing Address
_____ (Street Address) (PO Box #)
_____ (City) (State) (Zip)

AM Bus_____ **PM Bus_____**

* Parents/guardians have the right to refer their child for an evaluation for the purposes of special education services or programs. For more information, refer to "Parents Guide to Special Education" at nysed.gov/specialed or contact Julie Widen, Director of Special Education at 716-665-6624 ext. 4224.

Contact Information List order of contact (1st, 2nd, etc)	Name & Order of Contact	Home Ph	Cell Ph	Employer	Work Ph	Custody/ Placement
Parent/Guardian living w/student						
Parent/Guardian living w/student						
Parent **not** living w/student						
Emergency Contact 1/Relationship						
Emergency Contact 2/Relationship						

☐ I have completed the NYS Education Department's Housing Questionnaire as required under the McKinney-Vento Act. _____
Initials

Children in Household	Last Name	First Name	Date of Birth	Grade in School

Others in Household	Last Name	First Name	Date of Birth	Relationship to Student

Physician's Name _____ **Office Telephone** _____

School Services being received:

- ☐ Free/Reduced Lunch
- ☐ Academic Intervention Services - ELA/Math/Science/Social Studies
- ☐ Special Education Services
- ☐ 504 Plan
- ☐ Tuition Student
- ☐ Other (Please describe): _____

Please list persons who have permission to pick up your child

_____
_____
_____
_____
_____

Please list persons who <u>do not</u> have permission to pick up your child

_____
_____
_____
_____
_____

(Please attach custodial order or restraining document if biological parent is <u>denied</u> school visitation/pick-up)

Child Care Provider - Before or After School Care (Day Care or Babysitter):

Name _____ **Telephone Number** _____ **Day(s)** _____
(Last) (First)

Address _____ **Morning** _____ **Afternoon** _____
(City) (State) (Zip)

_____ _____
Parent/Guardian Signature Date

HOUSING QUESTIONNAIRE

Name of LEA: Falconer Central School

Name of School: ☐ Temple Elementary ☐ Fenner Elementary ☐ Falconer Middle/High

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

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

Falconer Central School District
2 East Avenue N., Falconer, NY 14733
Phone: (716) 665-6624
Fax: (716) 665-9265
Superintendent: Stephen Penhollow
Director of Curriculum & Instruction and
District Data Coordinator: Judith Roach

Falconer High School Principal: Jeffrey Jordan
Falconer Middle School Principal: Terry English
Harvey C. Fenner Elementary Principal: Gary Gilbert
Paul B.D. Temple Elementary Principal: Holly Hannon
Director of Special Education: Julie Widen
STEAM Coordinator: Mary Plumb

PARENT AFFIDAVIT OF RESIDENCY

In accordance with Chancellor's Regulation A-101, if a parent is subletting an apartment or home, or if more than one family shares a living space and there is only one leaseholder or homeowner, the parent must present an attested "Address Affidavit" signed both by the primary leaseholder as well as the parent affirming that the family is residing in this home, and must attach the lease or deed. Doubled-up families do not need to submit this form.

Section A: STUDENT INFORMATION – Please print clearly in ink

Student's Last Name		Student's First Name
Date of Birth (mm/dd/yyyy)	OSIS #/Student Id #	Telephone Number
Student's Current Address (House #, Street, Apt #, City, State and Zip Code)		

Section B: PARENT INFORMATION – Please print clearly in ink

Parent/Guardian's Last Name		Parent/Guardian's First Name	
Parent/Guardian's Current Address (House #, Street, Apt #, City, State and Zip Code)			
Home Phone Number	Work Phone Number	Cell Phone Number	Email Address

Section C: PRIMARY RESIDENT/TENANT INFORMATION – Please print clearly in ink

Primary Resident/Tenant's Last Name		Primary Resident/Tenant's First Name	
Primary Resident/Tenant's Current Address (House #, Street, Apt #, City, State and Zip Code)			
Home Phone Number	Work Phone Number	Cell Phone Number	Email Address
Relationship to Parent		Anticipated Duration of Stay	

To be completed by the Parent:

I, _____, the parent of _____,
(insert name and date of birth of student)

hereby affirm that I am residing with _____
(insert name)

at the following address _____.
(insert address and contact number of primary leaseholder)

.

In the event that my residency changes, I agree to notify my child's school and present new proof of address.

Parent Signature: _____

To be completed by Primary Leaseholder/Tenant:

I hereby affirm that

_____

(insert name of parent and child/children)

are residing with me at

_____
(insert address)

I understand that by signing this affidavit I am verifying the residence of:

_____.
(insert names)

Primary Leaseholder Signature: _____

This record (document) was acknowledged before me on _____by_____
Date Name of Individual

_____
Signature of Notary

My commission expires:_____

Falconer Central Schools: Transportation Information

Please List All Students in Your Household Below

All busing info: Please contact Mr. Scott Peterson at the Bus Garage, 716-665-5290

Student Last Name :	**First Name:**	
DOB:	Grade:	
Student Last Name :	**First Name:**	
DOB:	Grade:	
Student Last Name :	**First Name:**	
DOB:	Grade:	
Student Last Name :	**First Name:**	
DOB:	Grade:	
Student Last Name :	**First Name:**	
DOB:	Grade:	
Parent/Guardian:		
Address:	City:	Zip:
Home Phone:	Cell Phone:	
Work Phone:	House Description:	
PICK UP LOCATION : (Please check one)	_____**Home** _____**Other**	
If other: Adult's name:	Phone:	
Address:	House Description:	
DROP OFF LOCATION : (Please check one)	_____**Home** _____**Other**	
If other: Adult's name:	Phone:	
Address:	House Description:	
Emergency Contact (someone other than the parent)		
Name:	**Phone:**	
UPK through 5th Grade: EMERGENCY CLOSING DURING THE SCHOOL DAY (see reverse)		
Select ONE:	_____In case of emergency closing, my child may go home as usual.	
I have carefully and completely discussed this procedure with my child.	_____In case of emergency closing, my child will go to this in-District address	
	Name :	
_____<< Initials here	Street: City:	

Falconer Central School District

Student Health History Form

Student:	School:	Grade/Teacher:
Address:	Birth Date:	Gender:
Student's Doctor/Healthcare Provider:		Phone:
Student's Dentist:		Phone:
Student's Eye Doctor:		Phone:

Indicate if student has been diagnosed by a licensed healthcare provider with any of the following:

Health Condition	***Yes***	***No***	***Explanation if "Yes"***
Medication Allergies			List:
Food Allergies	☐	☐	Food(s): ☐ Peanut ☐ Dairy ☐ Eggs ☐ Other _____ Rate Reaction ☐ Mild ☐ Moderate ☐ Life-Threatening Does your child require an EpiPen? ☐ Yes ☐ No
Allergy to Bee Stings	☐	☐	Rate the reaction: ☐ Mild ☐ Moderate ☐ Life-Threatening Does your child require an EpiPen? ☐ Yes ☐ No
Allergies (Other)	☐	☐	List:
Asthma	☐	☐	Rate the Severity: ☐ Mild ☐ Moderate ☐ Life-Threatening Asthma Medication(s) taken:
Diabetes	☐	☐	☐ Type 1 (Insulin Dependent) ☐ Type 2 Diabetes medication(s) taken:
Seizure Disorder	☐	☐	Type of seizure: Medication(s) taken:

Health Condition	***Yes***	***No***	***Explanation if "Yes"***
Neurological Disorder	☐	☐	Specify:
Heart Condition	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
Bowel/Bladder Issues	☐	☐	Specify:
Migraine Headaches	☐	☐	Triggers: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health/Behavioral Issues	☐	☐	Specify: Medications/Treatment:
Wears Glasses/Contacts	☐	☐	☐ Glasses ☐ Contacts ☐ For Distance ☐ For Reading
Hearing Loss	☐	☐	☐ Right Ear ☐ Left Ear ☐ Hearing Aid(s)
Other Serious Illness	☐	☐	Specify: Date of Onset:
Serious Injury	☐	☐	Specify: Date(s):
Surgery	☐	☐	Specify: Date(s):
Medication Taken at Home (If not already listed)	☐	☐	List:

Please list other concerns that you would like the school to be aware of:

_____

_____

_____ _____

Parent/Guardian Signature Date

Please return this form to Heather L. Young, Central Registration
hyoung@falconerschools.org
If your child requires medication(s) at school, please have your child's physician fax a script to: Paul B.D. Temple Elementary – Fax Number - 716-267-9420
H.C. Fenner Elementary – Fax Number – 716-665-6668
Falconer Middle/High School – Fax Number - 716-665-6704

Falconer Central School District

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your 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 dent
al 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

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: