

In accordance with New York State Regulations, you **MUST** provide the following items to register your child:

_____ COPY OF CHILD'S BIRTH CERTIFICATE

_____ PROOF OF RESIDENCY (EXAMPLES: PAY STUB, INCOME TAX FORM, DEED OR LEASE AGREEMENT TO HOUSE OR APARTMENT, UTILITY OR OTHER BILLS SENT TO YOUR NEW HOME ADDRESS, OFFICIAL NYS DRIVERS LICENSE, STATE OR GOVERNMENT ISSUED I.D.)

_____ PROVIDER PROOF OF IMMUNIZATION RECORDS, THIS MEANS PROOF FROM YOUR DOCTORS OFFICE OR CLINIC, NOT JUST SCHOOL RECORDS. IF A STUDENT IS COMING FROM OUT OF NYS THEN THEY WILL ALSO NEED A NYS PHYSICAL.

_____ COPY OF CUSTODY PAPERS, COURT ORDERS, ORDERS OF PROTECTION (If applicable)

_____ FORM **DS 2999** FOR FOSTER CHILDREN (If applicable)

The District must have each of these items or your child **WILL NOT** be permitted to complete the registration process.

HORNELL CITY SCHOOL DISTRICT REGISTRAR (GRADES K-12): MRS. LIZ NORTON PUPIL PERSONNEL OFFICE, 134 SENECA ST., HORNELL, NY 14843. PHONE: 607-324-1303 EXT 1109, FAX: 607-324-1346, EMAIL: Elizabeth.norton@hornellcsd.org

Summer office hours are 7:30AM to 3:30PM, Monday through Thursday (Closed for lunch 1:00-2:00)

Enter Date: _____ School Name: _____ Student ID#: _____

STUDENT REGISTRATION FORM

 Student Name: _____ Grade Entering: _____ Gender: Male Female
Legal Last Name First MI

 Street Address: _____
Street Name Apt. # City State Zip

 Mailing Address: _____
Street Name Apt. # City State Zip

 Home Phone: _____ Unlisted: (check if yes)

 Birth Date: _____ Birth Place: _____
Month/Day/Year City & State (or Country)

 Last School Attended: _____
Name, Mailing Address and Telephone Number
Race - Select one or more

-
- White (W)
-
-
- Asian (A)
-
-
- Black (B)
-
-
- Indian/Alaskan Native American (I)
-
-
- Native Hawaiian/Other Pacific Islander (P)

Attended Hornell Previously? School: _____

 Is the Student a Citizen of the United States? Yes No

 Hispanic/Latino Origin: Yes No

Primary Language Spoken at Home: _____

Student's Primary Language: _____

 If language is other than English, does the student read/write/speak English? Yes No
(Circle all that apply)
IMMIGRANT INFORMATION

 Date of Entry into U.S. _____ No. of Years In US Schools: _____
 Country of Origin: _____

PARENT/GUARDIAN INFORMATION

 Student Lives with: Both Parents Father Only Mother Only Father/Stepmother Mother/Stepfather
 (Circle One) Foster Parents Guardian Relative: _____ Other: _____

FAMILY STATUS
 Father Step-Father Legal Guardian Foster Parent

Name: _____

 Living in Household: Yes No

 Address: _____

Home Phone: _____ Cell: _____

E-Mail: _____

Employer: _____

Work Phone: _____

 Mailing Address, if different: _____

FAMILY STATUS
 Mother Step-Mother Legal Guardian Foster Parent

Name: _____

 Living in Household: Yes No

 Address: _____

Home Phone: _____ Cell: _____

E-Mail: _____

Employer: _____

Work Phone: _____

 Mailing Address, if different: _____

OTHERS LIVING IN HOUSEHOLD

Name	Relationship to Student	Sex	Age	School	Grade

CUSTODY INFORMATION

- Two Parents in Home Custody/Placement Transfer Single Parent
- Joint Custody Separated Emancipated
- Sole Custody Foster Placement (DSS-2999/3424 must be provided)

RESTRICTIONS OF CONTACT & INFORMATION (Paperwork MUST be provided)

- Custody Papers Specify Restriction No Restrictions for Parents/Guardians Copy of Papers Provided
- Restriction: _____
- Order of Protection Against: _____ Expires: _____
- Other Restriction: _____

EMERGENCY CONTACT INFORMATION (Other than Parent/Guardian)

1st Contact: _____ Phone: _____ Relation to Student: _____

Address: _____

Street Name Apt. # City State Zip

2nd Contact: _____ Phone: _____ Relation to Student: _____

Address: _____

Street Name Apt. # City State Zip

3rd Contact: _____ Phone: _____ Relation to Student: _____

Address: _____

Street Name Apt. # City State Zip

STUDENT EDUCATIONAL SERVICES

- Does your child currently have an IEP? _____ Yes _____ No
- Does your child currently have a 504 Plan? _____ Yes _____ No
- Has your child ever repeated a grade in school? Grade: _____ _____ Yes _____ No

Check any services listed below that your child has received in the past school year:

- _____ Remedial Math _____ Occupational Therapy
- _____ Remedial Reading _____ Physical Therapy
- _____ Speech _____ School Counseling
- _____ ESOL (English as a Second Language) _____ Counseling from an Outside Agency

HOUSEHOLD/RESIDENCY STATUS

What is the current housing arrangement for the above named student(s)? Students who are in temporary housing may be protected by the McKinney-Vento Act.

Students who are protected under this act may be entitled to other services. The answers you give will help the district determine what services you or your child may be eligible to receive.

- Permanent (Check one below)
- Residence Type: Lease Own Rent Trailer park/Condo Unit Move in Date: _____
- Temporary (Check one below)
- with another family/doubled up (due to economic hardship and not as a matter of convenience)
 - In a shelter In a hotel/motel In an abandoned building
 - In a car, park, bus, train, or campsite
 - Other _____

Date: _____

Signature of Parent/Guardian



Lisette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

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

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

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled *Language Background and Educational History*. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First Middle Last

DATE OF BIRTH:

Month Day Year

GENDER:

- Male
 Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name First Name Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

- What language(s) is(are) spoken in the student's home or residence? English Other _____
specify
- What was the first language your child learned? English Other _____
specify
- What is the Home Language of each parent/guardian? Mother _____ Father _____
specify *specify*
 Guardian(s) _____
specify
- What language(s) does your child understand? English Other _____
specify
- What language(s) does your child speak? English Other _____ Does not speak
specify
- What language(s) does your child read? English Other _____ Does not read
specify
- What language(s) does your child write? English Other _____ Does not write
specify

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: Mother Father Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: No Yes

**DATE OF INDIVIDUAL INTERVIEW:

Mo. DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW:

- ADMINISTER NYSITELL
 ENGLISH PROFICIENT
 REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION:

Mo. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:

- ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Student Residency Questionnaire* Hornell City School District

* This questionnaire should be completed for each newly registering student as well as each time a student changes his or her address. Multiple students may go on one form as long as they are all in the same school building in Hornell and all students are residing in the same place.

Check All That Apply: New Registrant Transferring From Another District Change Of Address

Name Of Student (Last, First, Middle)	Name Of Hornell School	Grade	Gender	Date Of Birth	If Transferring, Last District Attended

Current Address: _____

Former Address (required for change of address and transferring students): _____

Current Telephone Number(s): _____

What is the current housing arrangement for the above named student(s)?

- Permanent** (You do not need to complete the rest of this form)
 Temporary while we work out other arrangements (please complete the remainder of this form)

Students who are in temporary housing may be protected by the McKinney-Vento Act. Students protected by the 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 certificates. Students who are protected under this act may also be entitled to other services. The answers you give below will help the district determine what services you or your child may be able to receive.

- In a shelter In a hotel/motel In a car, park, bus, train, or campsite
- Temporarily** sharing housing of other persons due to loss of housing or economic hardship
- In other **temporary** housing situation (please describe) _____

Name of Parent, Guardian, or Student (if unaccompanied, homeless youth):

_____ Printed Name

_____ Signature

_____ Date

Guidance Office:

If the student lives in anything other than permanent housing, please send a copy of this form to the district's McKinney-Vento Liaison. If the student is living in temporary 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 liaison is required to assist the student in obtaining the necessary documents after the student has been enrolled.

Is this family having difficulty obtaining documents? Yes No

Does this family wish to be contacted by the McKinney-Vento Liaison about possible services? Yes No

I certify the above named student(s) qualified for the Child Nutrition Program under the provisions of the McKinney-Vento Act. A STAC-02 form will be filed by my office.



HORNELL

CITY SCHOOL DISTRICT

25 Pearl Street • Hornell • New York • 14843

Jeremy Palotti, Superintendent
Phone 607.324.1302
FAX 607.324.1345

Schools

Senior High	324-1303
Intermediate	324-1304
Bryant	324-2171
N. Hornell	324-0014

CONSENT TO RELEASE AND ACQUIRE INFORMATION

To any treatment agency, I hereby authorize the release and discussion of records by the Hornell City School District.

I also authorize the Hornell City School District to acquire and discuss records including, but not limited to, psychological, psychiatric, medical, attendance, probation, discipline, court related, report cards, speech, counseling, occupational therapy and physical therapy, which pertain to the programming and placement of:

STUDENT NAME

Date of Birth

PARENT SIGNATURE

Date

Phone Number(s)



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STUDENT NAME: _____

MEDIA, WEB PHOTO AND INTERNET RELEASE:

MEDIA RELEASE

Local newspapers and occasionally TV stations attend school events or interview students about important issues. This may include artwork by your student, photographs, interviews and/or recording that may be published in newspaper, television informational material and/or the district website and BOCES publications. Please check the appropriate space granting or denying your permission.

_____ YES, PERMISSION GRANTED _____ NO, PERMISSION DENIED

WEB PAGE RELEASE

The school district website includes photographs of students. These children are not identified by name. Please check the appropriate space granting or denying your permission.

_____ YES, PERMISSION GRANTED _____ NO, PERMISSION DENIED

INTERNET ACCESS

The Hornell City School District uses a BOCES operated internet filtering service that prevents the display of content inappropriate for students. The content that students will be denied access to includes sexually explicit material, graphically violent material, material relating to hate groups and their message, profanity, chat sites, and sites that gather personal information. Material advocating illegal activity such as drug use, bomb making, underage drinking and gambling, information on committing murder or suicide and sites that promote plagiarism or cheating are also inaccessible to anyone using the district's network. While we are very satisfied with our filtering software, you should know that no solution is perfect. All filtering software may block innocent sites and allow some inappropriate sites to slip through. Using the internet is a privilege, not a right. The district expects your child to show respect for technology and use it appropriately or they will forfeit this opportunity.

As the parent or legal guardian of the minor named on this document, I am granting permission for my child to access the internet under adult supervision. I also understand that individuals and families may be held liable for violations and I am accepting responsibility for conveying standards for my child to follow when selecting, sharing or exploring information on the internet.

PARENT /GUARDIAN SIGNATURE

Date



North Hornell – 324-0014
Bryant – 324-2171
Intermediate School -324-1304
Junior/Senior High – 324-1303

Health Services Guidelines

1. **School Physicals:** A physical is necessary for all students entering into public school as mandated by New York State for the following: **All New Entrants, Pre-K/K, 1st, 3rd, 5th, 7th, 9th and 11th** grade students. If your child has had a physical within a year of the first day of entering please be sure to provide a copy to your school nurse. Physicals are to be done by a physician licensed to practice in New York State and shall include **BMI** (body mass index) and **WSC** (weight status category) information which will be reported to NYS without the use of names. Parents may opt out of having their child's WSC reported to NYS by signing an "opt out" request and returning it to the respective school health office.

Physicals are offered at school for newly enrolled students, students in the mandated years, playing sports (required annually) and for working papers.

2. **Immunization record:** An **official** immunization record from a physician's/public health office is required for entry in NYS schools. This record **must be produced within 14 calendar days of admission** to school, **30 days if coming from out of state.**

New York State Department of Health requires that each student comply with the following immunization requirements: HIB-Pre-K 1-4 doses, PCV- Pre-K 1-4 doses, DTP-4 or more doses , Polio-Pre-K 3 doses, K-12- 4 or more with the 4th dose being given no more than 4 days before the 4th birthday but before the 7th birthday, MMR- Pre-K 1 dose, K-12- 2 doses , Hepatitis Series- 3 doses, Varicella(chicken pox)- Pre-K,5th,11th and 12th- 1 dose, 2 doses for all others, and TDAP- 1 dose for all students entering grades 6 - 12. **ALL STUDENTS ENTERING: 7th, 8th, 9th and 12th grades- MUST have the MENINGOCOCCAL VACCINE – THEY CAN NOT START SCHOOL WITHOUT IT.** Again if you have already provided proof of this to the school nurse thank you, nothing further needs to be done.

3. **Hearing, Vision and Scoliosis:** The school nurse will do vision screening for all new students as well as students in grades Pre-K/ K,1,3,5,7 ,11 and upon request. Scoliosis screenings will be done for girls in grades 5 & 7 and boys in grade 9, any abnormal finding will be reported to the students' parent/guardian.

4. **Physical Education Restrictions:** NYS requires that all students participate in physical education. If your child has an illness or injury which prevents them from performing normal activities, please ask their physician to document what they can do safely and bring the note to the nurse's office. When your child can return to normal activities a written release from the doctor is also required to be brought in.

5. **Medication:** Any medication that must be taken during school hours must be brought to the nurses office in its original container with the label intact. A parent should bring the medication to school with a permission form signed by the physician and the parent. The medication will be kept in the nurses office and administered at the proper time. Even over the counter medications such as: Tylenol, Advil, cold formulas, topical, eye medication, etc. must be ordered by a physician and signed by a parent in order to be given in the school setting.



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (HIPPA)

Student Name _____ Birthdate: _____

Healthcare Provider (doctor) _____ Phone: _____

Address _____ Fax: _____

Healthcare Provider (doctor) _____ Phone: _____

Address _____ Fax: _____

Healthcare Provider (doctor) _____ Phone: _____

Address _____ Fax: _____

I hereby authorize my/my child's physician(s) listed above to exchange the following information with the Hornell City School District, including:

- School Nurse
- Medical Officer
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Audiologist
- Vision Department
- Special Education
- Other _____
- Immunizations to comply with NYS regulations
- Physical exams to comply with NYS regulations and sports requirements
- Authorization for medications during the school day or on school bus
- Medical clearances as needed following an injury or change in condition
- Medical orders required for therapy needs, evaluations
- Physician referral for services (OT, PT)
- Medical condition/treatment plans that may have an impact in the school environment
- Other _____

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon signing this release however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment.

This release expires on the last day of the enrollment of the above student in the Hornell City School District, and may be revoked at any time by sending a written and signed request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt by the District. Protected health information will not be disclosed without consent pursuant to the Family Educational Rights and Privacy Act (20 U.S.C § 1232g) and implementing regulations (34 C.R.F. §99). A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the Hornell City School District by the healthcare providers listed above.

(Signature of student over 18 or Parent/Guardian)**

(Date)

** If student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, state authority to act on student's behalf: _____. ** If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act and the information requested pertains thereto, then the parent/guardian must also sign consent form.



HORNELL

CITY SCHOOL DISTRICT

25 Pearl Street • Hornell • New York • 14843

Jeremy Palotti, Superintendent
Phone 607.324.1302
FAX 607.324.1345

MEDICAL INFORMATION & EMERGENCY FORM

Student/Minor Information:

Name (first, middle, last) _____

Address: _____

Student/Minor's Primary Physician:

Name (first, middle, last): _____ Phone (_____) _____

Medical Conditions:

Please list any medical conditions of the student/minor (ex. asthma, diabetes, epilepsy, etc.) _____

List any allergies or allergic reactions to medications of the student/minor: _____

List any medications the student/minor is currently taking: _____

Other pertinent medical information: _____

Date of student/minor's most recent tetanus shot: _____

EMERGENCY CONTACTS:

Parent or Guardian

Name (first, middle, last) _____

Daytime phone: (_____) _____ Cell Phone (_____) _____ Evening phone: (_____) _____

Relationship to student/minor: _____

Other contact

Name (first, middle, last) _____

Daytime phone: (_____) _____ Cell Phone (_____) _____ Evening phone: (_____) _____

Relationship to student/minor: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school. Should the need arise this information will be given to the proper medical authorities.

I, _____ (parent/guardian) understand that in the case of illness or injury to my child _____ (child's name), the school will try to notify me or the person I have listed on the other side of this form as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school to (1) arrange for transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and (2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature of parent/guardian

Date

Hornell City School District

Permission to Administer Medication

Student Name: _____ DOB: _____

Grade: _____ Teacher/HR: _____ School: _____

To Be Completed By Health Care Provider

Diagnosis _____

Medication _____ Dose _____ Route _____ Time(s) _____

Duration- start date- _____ stop date- _____ ICD Code _____

All medication should be given as close to the prescribed time as possible, however may be given up to one hour before and no later than one hour after the prescribed time. Please advise the school if there is a time-specific concern regarding administration of the medication.

Please check all that are applicable:

If morning dose is not given at home, nurse may administer morning dose of _____ after verbal or written notification from parent. Please advise parent to send in additional medication

Medication is required: On bus On field trips On school-sponsored after school/weekend activities/sports

I assess this student to be self-directed* regarding this medication.

*They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently.

I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self-carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies.

Name, Title and License Number of Prescriber (Please Print) _____

Prescriber's Signature _____ Date _____ Phone _____

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature _____ Date _____ Phone _____

Additional Permission for Self-Administer/Self Carry (Requires Health Care Provider Consent Above)

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature _____ Date _____ Phone _____

School Nurse: _____ School _____

Phone: _____ Fax: _____

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal: _____

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Vision - without glasses/contact lenses</td> <td style="width: 10%;">R</td> <td style="width: 10%;">L</td> <td style="width: 20%; text-align: center;">Referral</td> </tr> <tr> <td>Vision - with glasses/contact lenses</td> <td>R</td> <td>L</td> <td></td> </tr> <tr> <td>Vision - Near Point</td> <td>R</td> <td>L</td> <td></td> </tr> <tr> <td>Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td>R</td> <td>L</td> <td></td> </tr> </table>	Vision - without glasses/contact lenses	R	L	Referral	Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
Vision - without glasses/contact lenses	R	L	Referral														
Vision - with glasses/contact lenses	R	L															
Vision - Near Point	R	L															
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / GSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerleading, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

**2018-2019 Community Eligibility Provision
Household Income Eligibility Form**

Hornell City School District is participating in the Community Eligibility Provision. All children in the school will receive meals at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete only one form for your household, sign your name and return it to the school named above. Call 607-324-1303, ext. 1570, if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. SNAP/TANF/FDPIR Benefits: If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here, and sign the application.

Name: _____ CASE # _____

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income

Name of household member	Earnings from work before deductions Amount / How Often	Child Support, Alimony Amount / How Often	Pensions, Retirement Payments Amount / How Often	Other Income, Social Security Amount / How Often	No Income
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: _____ Date: _____

Email Address: _____
Home Phone _____
Work Phone _____
Home Address _____

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAP/TANF/Foster Income _____ Total Household Income/How Often: _____ Household Size: _____
Free Eligibility _____ Reduced Eligibility _____ Denied Eligibility _____
Signature of Reviewing Official _____

CEPI/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1

ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.

- (1) Print the names of the children, including foster children, for whom you are applying on one form.
- (2) List their grade and school.
- (3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2

HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

- (1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
- (2) An adult household member must sign the form in PART 4. **SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4

ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
- (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly.** If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.

PRIVACY ACT STATEMENT

Confidentiality: The United States Department of Agriculture has approved the release of students names and eligibility status, without parent/guardian consent, to persons directly connected with the administration or enforcement of federal education programs such as Title I and the National Assessment of Educational Progress (NAEP), which are United States Department of Education programs used to determine areas such as the allocation of funds to schools, to evaluate socioeconomic status of the school's attendance area, and to assess educational progress. Information may also be released to State health or State education programs administered by the State agency or local education agency, provided the State or local education agency administers the program, and federal State or local nutrition programs similar to the National School Lunch Program. Additionally, all information contained in the free and reduced price application may be released to persons directly connected with the administration or enforcement of programs authorized under the National School Lunch Act (NSLA) or Child Nutrition Act (CNA); including the National School Lunch and School Breakfast Programs, the Special Milk Program, the Child and Adult Care Food Program, Summer Food Service Program and the Special Supplemental Nutrition Program for Women Infants and Children (WIC); the Comptroller General of the United States for audit purposes, and federal, State or local law enforcement officials investigating alleged violation of the programs under the NSLA or CNA.



**Hornell City School District
Transportation Department
25 Pearl Street, Hornell, NY 14843
(607) 324-2633**



*******APPLICATION INSTRUCTIONS*******

This application is used for student school bus transportation arrangements for the 2018-19 school year. With our continued focus on students' safety, we will not be able to take permanent transportation information over the phone. For your child's protection, we require detailed information regarding pick-up and drop-off arrangements with a parent or guardian's signature.

- A separate application is required for **EACH** student.
- A new application is required for **ANY** change that is made during the school year.
- A new application is required **EVERY** school year.
- **Failure to turn in an application will mean your child will not be scheduled for transportation.**

Due to the overwhelming amount of requests being processed, we require that all completed forms be returned to the District Office at 25 Pearl Street, Hornell, NY 14843. It will be forwarded to the bus garage as permanent instructions for the transportation of your child to and from school for the 2018-2019 school year. If your child will not need transportation, please indicate on the form and return to school or bus driver.

Students in grades PK-6 are eligible for transportation if they live 7/10ths of a mile or more from their school of attendance. Students 7-12 are eligible for transportation if they live 1.5 miles or more from their school of attendance.

We can accommodate one change per semester, if necessary. **If a change needs to be made, please contact our office as soon as possible to complete a new form.** We can be reached between 7:00 a.m. and 3:00 p.m. at 324-2633. **A minimum of three (3) school days is required to make a schedule change.** We are not allowed to transport students to any other address than is noted on this form. **WE CANNOT MAKE BUS CHANGES TO A DIFFERENT ADDRESS FOR PLAY DATES/SOCIAL DATES.** Once a schedule is established, it must remain consistent. Emergency situations may arise, please contact the bus garage at 324-2633 and we will attempt to assist with an emergency change. If your address changes, you must make the change through the "Parent Portal" or by calling the district office 607-324-1302 x 1109 and then notify the bus garage.

Students are required to arrive at their bus stop at least 5 minutes before the bus arrival time. Please remember that the first few weeks of school are hectic and buses may not be on "schedule". Therefore, your child may arrive home later than usual. Times may fluctuate according to traffic and weather conditions. School delays and cancellations are announced through our mass notification system as well as on all Hornell radio stations, local area television stations and the Hornell City School website (www.hornellcityschools.com).

PLEASE NOTE: YOU MUST STILL COMPLETE A FORM FOR YOUR CHILD(REN) EVEN IF YOU ARE NOT REQUESTING TRANSPORTATION SERVICES FROM THE DISTRICT. THERE IS A PLACE FOR YOU TO INDICATE THEY DO NOT REQUIRE TRANSPORTATION.

Hornell City School District
Transportation Department
25 Pearl Street, Hornell, NY 14843
(607) 324-2633



Directions: **PLEASE PRINT**

1. Complete an application for **EACH** child.
2. **A new application must be completed each year**
3. **Students may only have 1 pickup and 1 drop off point**
4. Daycare / Alternate site address must be located within the Hornell City School District.
5. If arrangements change, a new application must be completed.
6. Incomplete forms will not be processed.

My child does NOT require transportation by the district:

My child DOES require transportation by the district IF eligible:

Student Information:

Child's First Name: _____ Last Name: _____ Grade: _____

Contact Name: _____ Phone: _____

Primary/Home Location Information:

Address: _____ City: _____

Please circle the appropriate days below that student will be transported to/from primary (home) location.

AM home to school				
M	T	W	TH	F

PM school to home				
M	T	W	TH	F

Daycare or Alternate Information:

Daycare Contact Name: _____ Phone: _____

Address: _____ City: _____

Please circle the appropriate days below that student will be transported to/from Daycare or Alternate Site

AM from daycare or alternate site to school				
M	T	W	TH	F

PM to daycare or alternate site				
M	T	W	TH	F

Parent / Guardian Information:

Name of Parent / Guardian: _____

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

Parent / Guardian Signature: _____ Date: _____

By signing above, you are indicating that you have verified that your child's address and contact information is accurate and current with the district by confirming through the parent portal or other district correspondence.

**HORNELL CITY SCHOOL DISTRICT
2018-19 CALENDAR**

SEPTEMBER					OCTOBER					NOVEMBER					DECEMBER																																								
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F																																				
3	4	5	6	7	1	2	3	4	5				1	2	3	4	5	6	7																																				
Labor Day	Conf Day																																																						
10	11	12	13	14	8	9	10	11	12	5	6	7	8	9	10	11	12	13	14																																				
					Col. Day																																																		
17	18	19	20	21	15	16	17	18	19	12	13	14	15	16	17	18	19	20	21																																				
									Conf. Day	Vet. Day									ED PTC																																				
24	25	26	27	28	22	23	24	25	26	19	20	21	22	23	24	25	26	27	28																																				
												Thanksgiving Recess				Winter Recess																																							
					29	30	31			26	27	28	29	30	31																																								
JANUARY					FEBRUARY					MARCH					APRIL																																								
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F																																				
	1	2	3	4					1					1	1	2	3	4	5																																				
	New Year																																																						
7	8	9	10	11	4	5	6	7	8	4	5	6	7	8	8	9	10	11	12																																				
																			ED PTC																																				
14	15	16	17	18	11	12	13	14	15	11	12	13	14	15	15	16	17	18	19																																				
														Conf. Day		Spring Recess																																							
21	22	23	24	25	18	19	20	21	22	18	19	20	21	22	22	23	24	25	26																																				
MLK	Regents	Exams			Pres. Day	February		Recess																																															
28	29	30	31		25	26	27	28		25	26	27	28	29	29	30																																							
Conf Day																																																							
MAY					JUNE					<p>SHADED AREA INDICATES NO SCHOOL FOR STUDENTS.</p> <table border="0"> <thead> <tr> <th></th> <th><u>Staff</u></th> <th><u>Students</u></th> </tr> </thead> <tbody> <tr> <td>September</td> <td>19</td> <td>18</td> </tr> <tr> <td>October</td> <td>22</td> <td>21</td> </tr> <tr> <td>November</td> <td>18</td> <td>18</td> </tr> <tr> <td>December</td> <td>15</td> <td>15</td> </tr> <tr> <td>January</td> <td>18</td> <td>17</td> </tr> <tr> <td>February</td> <td>15</td> <td>15</td> </tr> <tr> <td>March</td> <td>21</td> <td>20</td> </tr> <tr> <td>April</td> <td>17</td> <td>17</td> </tr> <tr> <td>May</td> <td>22</td> <td>22</td> </tr> <tr> <td>June</td> <td><u>18</u></td> <td><u>18</u></td> </tr> <tr> <td></td> <td>185</td> <td>181</td> </tr> </tbody> </table> <p><i>ED* = Early dismissal for teaching staff and students. PTC = Parent Teacher Conference</i></p>											<u>Staff</u>	<u>Students</u>	September	19	18	October	22	21	November	18	18	December	15	15	January	18	17	February	15	15	March	21	20	April	17	17	May	22	22	June	<u>18</u>	<u>18</u>		185	181
	<u>Staff</u>	<u>Students</u>																																																					
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