

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)

Race - Select one or more

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

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

Last School Attended: _____
Name, Mailing Address and Telephone Number

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)

<u>IMMIGRANT INFORMATION</u>	
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
- Joint Custody
- Sole Custody
- Custody/Placement Transfer
- Separated
- Foster Placement (DSS-2999/3424 must be provided)
- Single Parent
- Emancipated

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? _____ Yes _____ No
- Grade: _____

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

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

Signature of Parent/Guardian _____

Date: _____



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

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

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

Home Language Questionnaire (HLQ)

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:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

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

 Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____

 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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING
 MO DAY YR.

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

25 Pearl Street • Hornell • New York • 14843

CITY SCHOOL DISTRICT

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)



HORNELL

25 Pearl Street • Hornell • New York • 14843

CITY SCHOOL DISTRICT

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

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 a new student. New York State also mandates physicals for RK/K, 2nd, 4th, 7th, and 10th grade students. Physicals are to be done by a physician licensed to practice in New York State (or equivalent) 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: 4 or more DTP, 4 or more Polio with the 4th dose being given no more than 4 days before the 4th birthday but before the 7th birthday, 2 MMRs to enter kindergarten, Hepatitis Series (3 doses), 2 doses of Varicella (chicken pox) for all entering kindergarten and 6th grade beginning in the 2014-2015 school year, and 1 dose Tdap for all students born on or after 1/1/94 and entering grades 6 - 12. **ALL STUDENTS ENTERING 7TH AND 12TH grade MUST have the MENINGOCOCCAL VACCINE – THEY CAN NOT START SCHOOL WITHOUT IT.**

3. **Hearing, Vision and Scoliosis**: The school nurse will do vision screening for all new students as well as students in grades K-3, 5, 7, 10 and upon request. Hearing screenings are also done for new students and those in grades K, 1, 3, 5, 7, 10 and upon request. Scoliosis screenings will be done for grades 5-9. 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 nurse's 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 nurse's 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.

Your healthcare provider will require the release of information form below to share Protected Medical Information with the school district. Please sign and give the form to your healthcare provider and/or to your school nurse to avoid delays.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize my child's healthcare provider(s) listed below to release my child's _____ medical records to the district's medical officer, physical (PT), occupational (OT), speech therapists (ST) and/or school nurse:

Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____
Name _____	Phone _____	FAX _____

The healthcare provider may disclose the following protected health information: (check all that apply)

- Immunizations
- Health Appraisals
- Past/Current Medical Condition and Its Impact on Attendance, School Programming, and/or PT, OT, ST needs
- Other _____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (check all that apply)

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery and/or therapy prescriptions for PT, OT, ST
- At patient's request with no specified purpose
- Other _____

Please select one:

- This authorization is valid for the entire academic school year 20__ - 20__
- This authorization shall expire on ____/____/____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building.

I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice.

I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

Date _____ Signature of Patient (Over 18), Parent, or Guardian _____ Relationship _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

A signed copy of this authorization must be given to the adult patient or parent of the minor child



HORNELL

25 Pearl Street • Hornell • New York • 14843

CITY SCHOOL DISTRICT

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: _____

**2017-2018 Community Eligibility Provision
Household Income Eligibility Form**

Homell 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

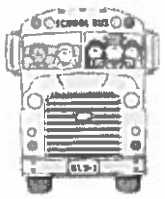
SNAP/TANF/Foster Income _____ Total Household Income/How Often: _____ Household Size: _____

Free Eligibility Signature of Reviewing Official _____ Reduced Eligibility _____ Denied Eligibility _____

**HORNELL CITY SCHOOL DISTRICT
2017-18 CALENDAR**

Approved on April 5, 2017

SEPTEMBER					OCTOBER					NOVEMBER					DECEMBER																																											
M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F																																							
			Aug 31 Conf. Day	1	2	3	4	5	6			1	2	3					1																																							
4	5	6		8	9	10	11	12	13	6	7	8	9	10	4	5	6	7	8																																							
Labor Day	Conf. Day				Col. Day									Vet. Day																																												
11	12	13	14	15	16	17	18	19	20	13	14	15	16	17	11	12	13	14	15																																							
									Conf. Day																																																	
18	19	20	21	22	23	24	25	26	27	20	21	22	23	24	18	19	20	21	22																																							
												Thanksgiving Recess																																														
25	26	27	28	29	30	31				27	28	29	30		25	26	27	28	29																																							
																	Winter Recess																																									
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	5				1	2				1	2	2	3	4	5	6																																							
New Year																																																										
8	9	10	11	12	5	6	7	8	9	5	6	7	8	9	9	10	11	12	13																																							
														Conf. Day																																												
15	16	17	18	19	12	13	14	15	16	12	13	14	15	16	16	17	18	19	20																																							
MLK																																																										
22	23	24	25	26	19	20	21	22	23	19	20	21	22	23	23	24	25	26	27																																							
	Regents	Exams		Conf. Day	Pres. Day	February Recess										Spring Recess																																										
29	30	31			26	27	28			26	27	28	29	30	30																																											
														No Sch.																																												
MAY					JUNE					<p>SHADED AREA INDICATES NO SCHOOL FOR STUDENTS.</p> <table border="0"> <thead> <tr> <th></th> <th>Staff</th> <th>Students</th> </tr> </thead> <tbody> <tr> <td>August</td> <td>1</td> <td>0</td> </tr> <tr> <td>September</td> <td>19</td> <td>18</td> </tr> <tr> <td>October</td> <td>21</td> <td>20</td> </tr> <tr> <td>November</td> <td>18</td> <td>18</td> </tr> <tr> <td>December</td> <td>16</td> <td>16</td> </tr> <tr> <td>January</td> <td>21</td> <td>20</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>18</td> <td>18</td> </tr> <tr> <td>May</td> <td>22</td> <td>22</td> </tr> <tr> <td>June</td> <td>16</td> <td>16</td> </tr> <tr> <td></td> <td>186</td> <td>181</td> </tr> </tbody> </table> <p>ED* = Early dismissal for staff and students.</p>											Staff	Students	August	1	0	September	19	18	October	21	20	November	18	18	December	16	16	January	21	20	February	15	15	March	21	20	April	18	18	May	22	22	June	16	16		186	181
	Staff	Students																																																								
August	1	0																																																								
September	19	18																																																								
October	21	20																																																								
November	18	18																																																								
December	16	16																																																								
January	21	20																																																								
February	15	15																																																								
March	21	20																																																								
April	18	18																																																								
May	22	22																																																								
June	16	16																																																								
	186	181																																																								
M	T	W	Th	F	M	T	W	Th	F																																																	
	1	2	3	4					1																																																	
7	8	9	10	11	4	5	6	7	8																																																	
14	15	16	17	18	11	12	13	14	15																																																	
	Conf. PM					Regents		Exam																																																		
21	22	23	24	25	18	19	20	21	22																																																	
					Regents	Exams																																																				
28	29	30	31		25	26	27	28	29																																																	
Mem. Day																																																										



**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 2017-18 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 2017-2018 school year. If your child will not need transportation, please indicate on the form and return to school or bus driver.

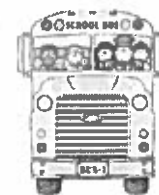
Students in grades PK-6 are eligible for transportation if they live 7/10ths of a mile or more from their school of attendance. Students 7-12 are eligible for transportation if they live 1.5 miles or more from their school of attendance.

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.