Johnson City Central School District
666 Reynolds Road
Johnson City, NY 13790
www.jcschools.com

~*~ WELCOME TO KINDERGARTEN ~*~

Dear Wildcat Families:

Our records indicate that your child is eligible to enter Kindergarten in September of this year! **Children who turn five on or before December 1, 2024 may enroll in Kindergarten for the upcoming school year.** We are excited to welcome your little one to Johnson City Elementary School!

Below you will find the registration process for Kindergarten for the 2024-2025 school year:

1. Complete the enclosed registration packet- this needs to be completed before you come in to register your child. This includes a brief questionnaire that will help us create class lists. **Please fill out the questionnaire using the QR code on the back of this letter.**
2. Call the student services office at (607)930-1008 to set up your registration appointment.
3. Appointments will be scheduled Monday-Friday between the hours of 9:00am- 2:00pm at **Johnson City High School**. The district will provide further directions on the location for the registration appointment when you call to schedule.
4. **YOU DO NOT NEED TO BRING YOUR CHILD WITH YOU FOR REGISTRATION.** You will need to present:
   - your child's birth certificate,
   - officially signed record of immunization
   - your photo ID
   - 2 proofs of residency for your Johnson City address.

****We will not be able to complete registration without this information****

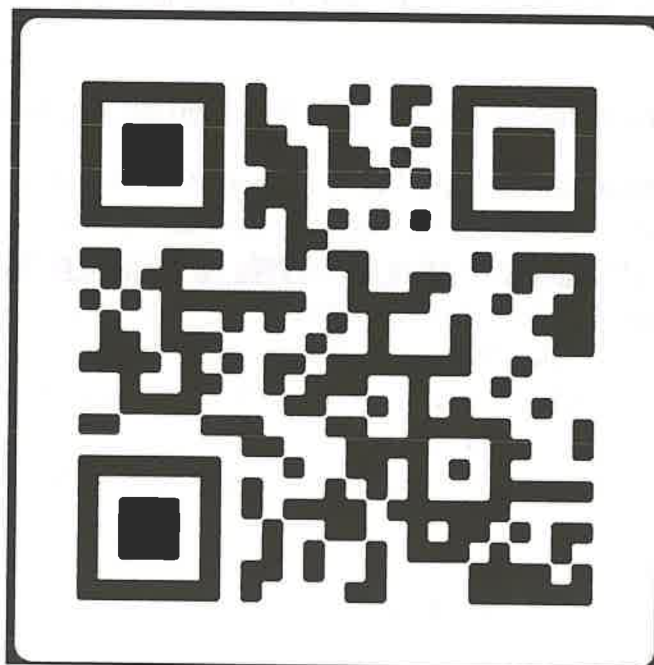
5. The enclosed Health Certificate/ appraisal Form should be taken to your pediatrician when you have your child's physical examination.
6. Students must be registered for school in order to attend any Kindergarten Readiness events that will take place starting in June.

If you should decide not to register your child in the Johnson City Central School District for any reason please contact the Central Registration office at (607)930-1008. Your call will help us in our class and staffing projections for the 2024-2025 school year. Also, if you move after registering your child, please contact our office.

Please continue to check out district webpage and Facebook page for updates on Kindergarten information!

Kindergarten Questionnaire

Use your phone's camera to scan the QR code. Then tap the link to fill out the form.



JOHNSON CITY SCHOOL DISTRICT
SCHOOL YEAR 20_____

FOR OFFICE USE ONLY:
STUDENT ID # BUILDING COUNSELOR CURRENT GRADE: _____
DATE APPROVED:

REGISTRATION FORM

PLEASE PRINT **PLEASE PRINT**

STUDENT NAME ____________________ (Last) (Jr/Sr/III/IV) (First) (Middle) SEX ________ (M/F/NB)

BIRTH DATE ________ (MM/DD/YY) BIRTHPLACE ________________ (City) (State) (Country)

SUPPORT SERVICES: IEP ________ Yes/No 504 ________ Yes/No

EVER ATTEND JC SCHOOL(Yes/No) ______________ If Yes, indicate the School and the Year ______________

LAST SCHOOL ATTENDED	
	NAME ______________
	ADDRESS ______________
	CITY ______________
	DATE LEFT ______________ CURRENT GRADE: ________

STUDENT RESIDENTIAL ADDRESS	STUDENT MAILING ADDRESS only if different than residential
ADDRESS ______________	ADDRESS ______________
APT # ______________	APT # ______________
CITY ______________	CITY ______________
STATE New York ZIP CODE ________	STATE New York ZIP CODE ________
PRIMARY PHONE ______________	PRIMARY PHONE ______________
NIGHTTIME RESIDENCE ☐ Yes ☐ No	

GUARDIAN

NAME ______________ (Last) (Jr/Sr/III/V) (First)
ADDRESS ______________ APT # ________
CITY ______________ STATE New York ZIP CODE ________
PRIMARY PHONE ________ CELL PHONE ________ WORK PHONE ________
EMAIL ADDRESS: ______________ Employer Name: ______________

Receive Mailings
YES / NO
Relationship to student
____
Living with student
YES / NO

GUARDIAN

NAME ______________ (Last) (Jr/Sr/III/V) (First)
ADDRESS ______________ APT # ________
CITY ______________ STATE New York ZIP CODE ________
PRIMARY PHONE ________ CELL PHONE ________ WORK PHONE ________
EMAIL ADDRESS: ______________ Employer Name: ______________

Receive Mailings
YES / NO
Relationship to student
____
Living with student
YES / NO

If student is not living with both parents, who has legal custody? ☐ Mother ☐ Father ☐ Other ________
Custody Documentation Received _____Yes _____No

GUARDIANS MARITAL STATUS: _____SINGLE _____MARRIED _____SEPARATED _____DIVORCED

(PLEASE TURN OVER AND COMPLETE BACK OF FORM)

STUDENT'S NAME: ______________________________

ADDITIONAL EMERGENCY CONTACTS OTHER THAN GUARDIAN

1. NAME ______________________________
(Last) (Jr/Sr/III/IV) (First) (Middle)

ADDRESS ______________________________ APT # ________

CITY ________________ STATE ________________ ZIP ________

RELATIONSHIP TO STUDENT ______________________________

HOME PH ____________ CELL PHONE ____________ WORK PH ____________

NAME & ADDRESS OF EMPLOYER ______________________________

2. NAME ______________________________
(Last) (Jr/Sr/II/IV) (First) (Middle)

ADDRESS ______________________________ APT # ________

CITY ________________ STATE ________________ ZIP ________

RELATIONSHIP TO STUDENT ______________________________

HOME PH ____________ CELL PHONE ____________ WORK PH ____________

NAME & ADDRESS OF EMPLOYER ______________________________

PHYSICIAN ____________ PHONE ____________ HOSPITAL CHOICE ____________

SIBLINGS OF STUDENT (Including siblings 0 – 4 years)

NAME ______________________ (First) Middle) (Last) SCHOOL SEX ____ M/F DOB ________ MM/DD/YY AT RESIDENCE ____ Y/N

NAME ______________________ (First) Middle) (Last) SCHOOL SEX ____ M/F DOB ________ MM/DD/YY AT RESIDENCE ____ Y/N

NAME ______________________ (First) Middle) (Last) SCHOOL SEX ____ M/F DOB ________ MM/DD/YY AT RESIDENCE ____ Y/N

NAME ______________________ (First) Middle) (Last) SCHOOL SEX ____ M/F DOB ________ MM/DD/YY AT RESIDENCE ____ Y/N

NAME ______________________ (First) Middle) (Last) SCHOOL SEX ____ M/F DOB ________ MM/DD/YY AT RESIDENCE ____ Y/N

ADDITIONAL INFORMATION: ______________________________

____

____

____

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.

SIGNATURE OF PARENT/GUARDIAN ________________ DATE ________

SIGNATURE OF SCHOOL OFFICIAL
WHO REGISTERED CHILD ________________ DATE ________

THIS FORM MUST BE SUBMITTED IN PERSON TO CENTRAL REGISTRATION,
666 REYNOLDS ROAD, JOHNSON CITY, NY

Johnson City Central School District
Student Racial and Ethnic Identification

Name of Student____

The Johnson City Central School District, in compliance with New York State Education Department requirements, has adopted a procedure which requires the collection and recording of the ethnic identity of students in accordance with the Federal categories and definitions. The information will be used to:

-Report information to the State and Federal Education Departments.
-Plan educational programs and make sure that they are readily available to all students.
-Analyze differences in academic performance, attendance and completion of school.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information.
To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the confidentiality regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

2. **Select one or more races from the following five racial groups** [For question (2) Check (√) all groups that apply to your child; check (√) **at least** ONE box.]:

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **ASIAN**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **BLACK OR AFRICAN AMERICAN**: A person having origins in any of the Black racial groups of Africa.

☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_______________________________________ _______________
Signature of Parent/Guardian/Other Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): ____________________

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: ______________________________

Name of School: ______________________________

Name of Student: ______________________________
Last First Middle

Gender: ☐ Male ☐ Female

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

Grade: ____ *(preschool-12)*

ID#: __________ *(optional)*

Address: ______________________________

Phone: ______________________________

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

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

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

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

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

____
Date

If **ANY box other than "In Permanent Housing" is checked,** , then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

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

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

CUESTIONARIO DE VIVIENDA

Nombre del Distrito Escolar: ____

Nombre de la Escuela: ____

Nombre del Estudiante: ____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer

Fecha de Nacimiento: _____ / _____ / _____ (*Mes* / *Día* / *Año*)

Grado: ______ (*jardín de infantes – 12)*

ID#: ______ (*opciónal)*

Dirección: ________________________________ Teléfono: ______________

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

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

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

____

- ☐ En un hogar permanente

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

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

____
Fecha

Si CUALQUIER caja que no sea "En un hogar permanente" está marcada, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción y **el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

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

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

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:
			❑ Male ❑ Female
Month	*Day*	*Year*	

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?	❑ 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?	❑ Mother ______ *specify*	❑ Father ______ *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 in the United States________

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:

Johnson City Central School District
New Student Health History

Name: ______________________________ Grade: _______ Entry Date: _____/_____/_____

Gender: ___M ___F Date of Birth: ____/____/____ Place of Birth (City, State) ______________________

Immunizations:

We must have a physician's signed statement or a certificate from a public health agency that the required immunizations have been given. All current, returning, and new students must meet the immunization requirements as set forth under New York State Public Health Law.

Does your child have any of the following life-threatening conditions? A "Life-Threatening Health Condition" is a condition, including a known allergy, which will put the child in danger during the school day if a medication or treatment order is not in place.

	YES	NO	TYPE/REACTION	MEDICATION
Food Allergy				
Bee Sting or Insect				
Asthma				
Diabetes				
Seizure Disorder				
Heart Condition				
Blood Disorder				
Latex				
Other				

Allergies: ______________________________

Current medications: ______________________________

Does your child have any dietary restrictions? ☐ Yes ☐ No

If so, please explain: ______________________________

I give my permission for a school physical to be completed at school.

☐ Yes

☐ No

Form completed by: ______________________ School: ______________________

Signature of parent/ guardian: ______________________ **Date:** ____/____/____

Johnson City Central School District
666 Reynolds Road
Johnson City, NY 13790
www.jcschools.com

Educational Excellence for a Changing Tomorrow

IMMUNIZATION/HEALTH INFORMATION REQUEST FORM

TO: ____

____

____

____

Re: ____ DOB: ________________________________

I authorize and request release of any and all immunization records and last physical examination concerning the above child to:

☐ **JC Primary School**
601 Columbia Drive
Johnson City, NY 13790
Attn: School Nurse
P: (607) 930-1316/1317
F: (607) 930-1431

☐ **JC Elem./Middle School**
601 Columbia Drive
Johnson City, NY 13790
Attn: School Nurse
P: (607) 930-1357/1358
F: (607) 930-1434

☐ **JC High School**
666 Reynolds Road
Johnson City, NY 13790
Attn: School Nurse
P: (607) 930-1551/1552
F: (607) 930-1653

I further request that party mentioned above release any and all information as may be required by you upon request.

____ **Signature**

____ **Relationship**

____ **Witness**

____ **Date**

Johnson City Central School District
666 Reynolds Road
Johnson City, NY 13790
www.jcschools.com

Educational Excellence for a Changing Tomorrow

Authorization for Release of Records

Date: ____/____/____

To: ____

____

____

____

Re: ______________________________ DOB: ____/____/____ Grade Level: _____

The above named student has registered in the Johnson City School District. Please forward his/her most recent records as soon as possible to the information indicated at the bottom of this sheet:

- ✓ Birth Certificate
- ✓ Scholastic Records
- ✓ Health & Immunization Records
- ✓ Standardized/State Test Scores
- ✓ Attendance Records
- ✓ Latest Report Card
- ✓ Discipline Records
- ✓ Transcripts/Exit Grades (HS)
- ✓ IEP or Section 504 Plan
- ✓ Psychological Report
- ✓ Social History
- ✓ All Recent Evaluations
- ✓ Other Pertinent Information
- ✓ OT and/or PT Script

____ ____________________

Signature of Parent/Legal Guardian **Date**

Relationship to Student: ____

Please fax/email records ASAP to the following:

Johnson City Student Services Office
666 Reynolds Road
Johnson City, NY 13790
Phone: (607) 930-1008
Fax: (607) 930-1144
Email: cliddic@jcschools.stier.org or Ltoner@jcschools.stier.org

Johnson City Central School District
666 Reynolds Road, Johnson City, New York 13790
Phone (607) 930-1008
www.jcschools.com

Opt-Out for Student Computer Network and Internet Access

Johnson City Central School District (JCCSD) provides network and Internet access to ***ALL*** students.

The use of JCCSD network and Internet access is to assist students in completing educational activities and should be used strictly under the rules and regulations that are defined in our district's "Acceptable Use Policy" as established by our Board of Education in policy 8630. This policy must be followed anytime there is a connection to the district's wired or wireless network.

If you DO NOT want your student to have access to the JCCSD network and Internet, please complete and submit this Opt-Out form to the school principal.

This opt-out form applies to the current school year and must be specifically renewed at the beginning of each school year.

Student Name: ______________________________
(please print)

Building: ______________________ Date: ______________
(please print)

School Year: ______________________ Grade: ______________

As the parent or guardian of this student I understand that by signing below I am requesting that my student's access to the JCCSD network and Internet be removed for the school year indicated above.

Parent / Guardian Name: ______________________________
(please print)

Parent / Guardian Signature: ______________________ Date: ______________

Johnson City Central School District
666 Reynolds Road Johnson
City, NY 13790
www.jcschools.com

Dear Parents and Guardians:

The Johnson City Central School District is committed to openly communicating with the parents of our students and the community as a whole. From time to time, local newspapers and television news crews come into our schools to report on our educational and co-curricular activities and individual student and class achievements. We encourage the positive community recognition of our students and programs in the local media and in our district and school publications.

If for any reason you **DO NOT** want your child filmed, photographed or to be quoted while participating in a school-related activity, the following form should be signed and returned immediately to the main office of your child's school. The form will be forwarded to the correct school personnel and we will respect your request. Again, this form **ONLY** needs to be returned if you **DO NOT** give your permission for your child to be filmed, photographed or quoted by the news media or included in any district or school publications. We appreciate your time and consideration of this matter.

Sincerely,

Superintendent of Schools

Please **DO NOT** allow my daughter/son to participate in activities that are being filmed or photographed or to be quoted by any representatives of the news media or to be used in any school or district publications.

______________________ ____ ______________________

Student's Name **Grade** **School & Teacher**

______________________ ______________________

Parent/Guardian Date

Creating Educational Opportunities for All Students in Preparation for Success in an Ever-Changing Community

Johnson City Central School District
Committee on Special Education
666 Reynolds Road
Johnson City, NY 13790 (607-930-1008)

Medicaid Consent

Date: ____________________

____
____
____

Student Name: ____________________________ DOB: _____/_____/_____

CIN#: ____________________________

Dear Parent/Guardian:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, ______________________________ as the parent/guardian of ____________________________________, have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- *Providing consent will not impact my child's/my Medicaid coverage;*
- *Upon request, I may review copies of records disclosed pursuant to this authorization;*
- *Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid and/or provide my child's CIN;*
- *I have the right to withdraw consent at any time; and*
- *The school district/county must give me annual written notification of my rights regarding this consent.*

___ I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me. I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (e.g. records or information about services your child receives, student demographic information):		
IEP	Session Notes	Other Personally Identifiable Information
Written Order/Referral	Medication Administration Report	Any Other Specific Records Pertaining to the Student's Services or Program
Evaluation Reports	Special Transportation Log	

___ I do not give consent to bill the Medicaid Insurance Program for special education and related services that are on my child's individualized education program (IEP). Regardless of my decision to deny consent, all required services in my child's IEP will be provided at no cost to me.

Parent/Guardian Signature: ______________________________

Print Name: ______________________________ Date: ____________________

Johnson City Central School District
666 Reynolds Road
Johnson City, NY 13790
www.jcschools.com

Educational Excellence for a Changing Tomorrow

PERMISSION TO FAX

______________________________ ______________________________

Student Name **DOB**

I authorize and request that my child's prescription for Occupational Therapy and/or Physical Therapy services be faxed to:

Johnson City School District
601 Columbia Drive
Johnson City, NY 13790
(F): (607) 930-1144

______________________________ ______________________________

Parent/Legal Guardian **Relationship**

Date: __________________________

Physician Name: ______________________________

Medical Group: ______________________________

Address: ______________________________

____

Physician Phone #: ______________________________

Physician Fax #: ______________________________

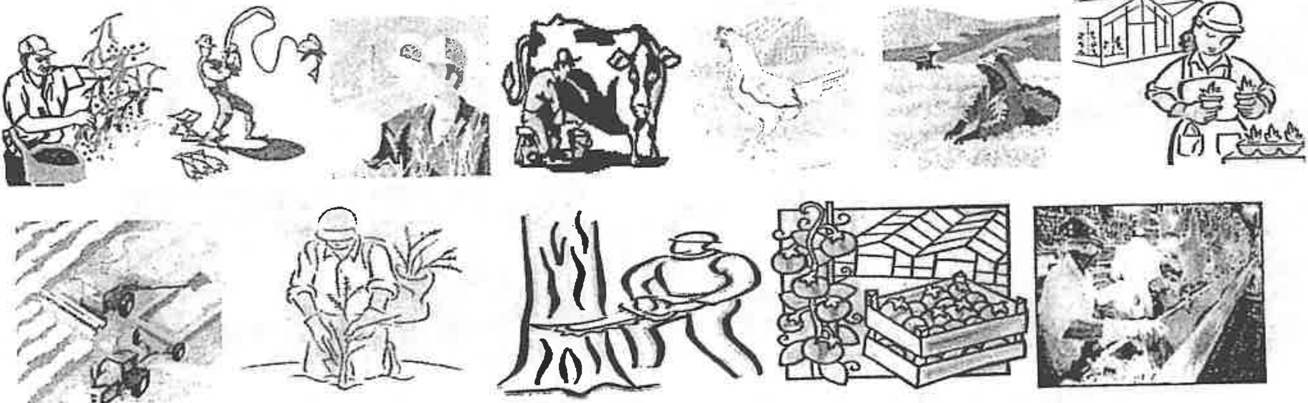
Identification & Recruitment Parent Survey

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: ______________________________

Home address: ______________________________

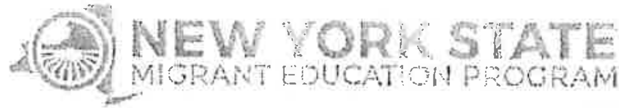
Telephone number: (_____)-________-________ Best time to be reached: _______ AM/PM

Previous Address: ______________________________

Student name: ______________________ Age ____________ Grade________

Student name: ______________________ Age ____________ Grade________

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.



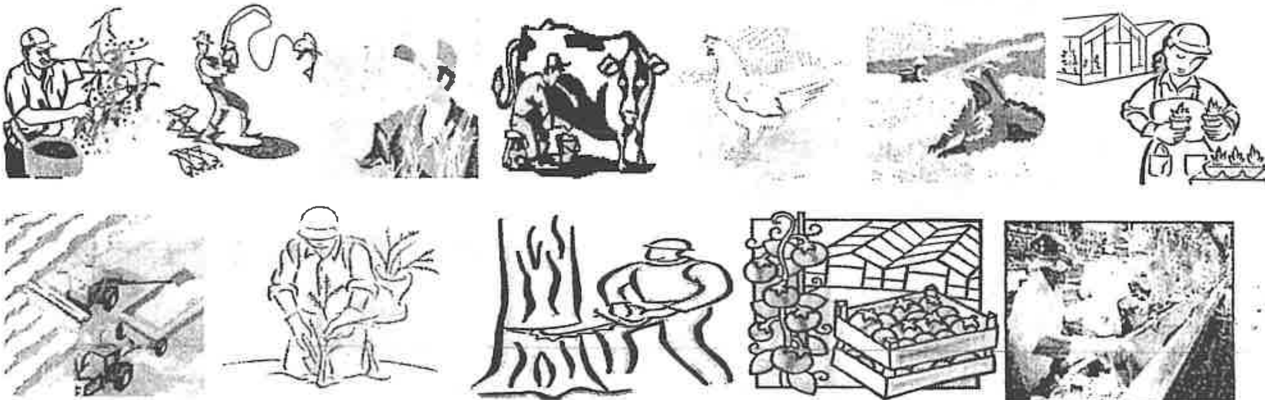
OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?

- ☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- ☐ Trabajando en la cultivación o procesamiento de los árboles.
- ☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.



Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: ______________________________

Dirección Física: ______________________________

Teléfono: (____)-______-______ Mejor tiempo para ser contactado ______ AM/PM

Dirección anterior: ______________________________

Nombre del estudiante: ____________________ Edad________ Grado________

Nombre del estudiante: ____________________ Edad________ Grado________

Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a
NYS Migrant Education Program- Identification & Recruitment Office
100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached	Date of last seizure: ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached	☐ Diabetes Medical Mgmt. Plan Attached

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

BMI________kg/m2

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

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

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

☐ **System Review and Abnormal Findings Listed Below**

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

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

Name:				DOB:
SCREENINGS				
Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : ____________

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.