Welcome to Cincinnatus Central School

Please be prepared to present the following when you come to register your child:

- **Birth Certificate** (preferred) or record of baptism

  If birth certificate is not available the following can be presented:
  - Passport
  - Official driver's license
  - School photo identification with date of birth
  - Consulate identification card
  - Hospital or health records
  - Military dependent identification card
  - Documents issued by federal, state or local agencies
  - Court orders or other court-issued document
  - Native American tribal document
  - Records from non-profit international aid agencies and voluntary agencies

- **Immunization Record**

- **Proof of Residency**

  Such documentation may include:
  - Copy of residential lease, a deed or mortgage statement
  - Statement by a third -party landlord
  - Pay stub
  - Income tax form
  - Utility or other bill
  - Membership documents (e.g. library cards) based upon residency
  - Voter registration document(s)
  - Official driver's license, learner's permit or non-driver ID
  - Documents issued by federal, state or local agencies
  - Evidence of custody of the child

- **Complete Registration Packet**

It would be helpful if a copy of your child's most recent report card is included with the registration packet. If your child special education services, please bring a copy of a current IEP/504 plan.

Parents/Guardians may also want to provide existing custody agreements and/or court orders.

To schedule an appointment, please call 607.863.3200, Ext. 1. Office hours are from 8 a.m. - 3 p.m. and 8:00 am to 2:00 pm during the summer.

Cincinnatus Central School Registration Form

Child's name _____ _____ _____
Last First Middle

Child's address _____ County _____

Gender: (please check) Male ☐ Female ☐ Is this child homeless? Yes ☐ (see back) No ☐

Date of Birth: Month _____ Day ____ Year _____ Place of Birth: _____

Is this student Hispanic, Latino, or 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 ☐ or No, not Hispanic ☐

Select one or more races from the following five racial groups. Check all groups that apply to you child: **Check at least ONE box.**

- ☐ American Indian or Alaska Native (origin of North, South, or Central America and who maintains tribal affiliation or community attachment.)
- ☐ Asian (origin of the Far East, Southeast Asia, or the Indian subcontinent)
- ☐ Native Hawaiian or other Pacific Islander (origin of Hawaii, Guam, Samos, or other Pacific Islands)
- ☐ Black or African American (origin of the Black racial groups of Africa)
- ☐ White (origin of Europe, North Africa, or Middle East)

Anticipated Start Date: _____ Entering Grade: _____

Last School Attended and Address: _____

Phone: _____ Fax: _____

Special Services: Is this student receiving any of the following: (Please check)

Resource Room ☐	Remedial Math ☐	Speech ☐
Physical Therapy ☐	Occupational Therapy ☐	Other ☐ _____
Remedial Reading ☐	Academic Enrichment Program ☐	IEP/504 ☐

_____ _____ _____
Father's Name Residence County

_____ _____ _____ _____
Mailing Address Home Phone Work Phone Cell Phone

_____ _____ _____
Mother's Name Ms. ☐ Mrs. ☐ Residence County

_____ _____ _____ _____
Mailing Address Home Phone Work Phone Cell Phone

_____ _____ _____
Legal Guardian Name Mr. ☐ Ms. ☐ Mrs ☐ Residence County

_____ _____ _____ _____
Mailing Address Home Phone Work Phone Cell Phone

Date Moved into Present Address: Month _____ Day _____ Year _____

Do you have Legal Custody of this student:	Yes ☐	No ☐	
Is this student a Foster Child:	Yes ☐	No ☐	Date Placed: _____
Has this student ever attended Cincinnatus:	Yes ☐	No ☐	When: _____
Dominant Language spoken in the home:	English ☐		Other: _____

Please list Siblings: (living in the home, school age and younger)

Name	Date of Birth	Grade

_____ _____ _____
Parent/Guardian Signature Date Relationship to Student

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: ____ /____ /____ Grade: ____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____ Phone: _____

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

Where is the student currently living? (*Please check <u>one</u> 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 **<u>ANY box other than "In Permanent Housing" is checked,</u>**, 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**. **<u>After</u>** 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.

PROGRAM SUPPORT SERVICES

Please circle any services your child has received:

- **>> Academic Intervention Services (AIS)<<**
- **>>Response to Intervention Services (RTI)<<**
- **>>504 Plan**
- **>>Related Services (Counseling, Speech, OT, PT)<<**
- **>>Special Education/IEP<<**

If you answered yes, you will be contacted to share information and review programming to meet your child's needs.

Thank you.

CINCINNATUS CENTRAL SCHOOL
STUDENT DATA CARD

(Please Print)

Student's Last Name:	First:	Mid Initial:	Birthdate: / /	Grade:	Sex: ☐ M ☐ F

Physical address Street:			Mailing Address Street (if different from Physical Address):		
City:	State:	ZIP Code:	City:	State:	ZIP Code:
Student Lives With:			Student Lives With:		

PARENT/GUARDIAN INFORMATION

Parent/Guardian Last Name:	First:		Home Phone: ( ) -	Relation to Student:
Parent/Guardian Address Street:			Cell Phone: ( ) -	Authorized to Pickup? ☐ Yes ☐ No
City:	State:	ZIP Code:	Work Phone: ( ) -	Custody? ☐ Yes ☐ No
Employer:			Email:	

Parent/Guardian Last Name:	First:		Home Phone: ( ) -	Relation to Student:
Parent/Guardian Address Street:			Cell Phone: ( ) -	Authorized to Pickup? ☐ Yes ☐ No
City:	State:	ZIP Code:	Work Phone: ( ) -	Custody? ☐ Yes ☐ No
Employer:			Email:	

Alternate Person(s) to Contact in the Event Parent is Not Available:

Name:	Relationship:	Home Phone: ( ) -	Work Phone: ( ) -	Authorized to Pickup? Y N Cell Phone: ( ) -
Name:	Relationship:	Home Phone: ( ) -	Work Phone: ( ) -	Authorized to Pickup? Y N Cell Phone: ( ) -

Primary Doctor: _____ Phone: _____

List any special health conditions, allergies or daily medications:

1. _____

2. _____

3. _____

4. _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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:
Month	*Day*	*Year*
		❑ 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.)

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 _____

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:

Survey:
Is anyone in your family eligible for Migrant Education Services?

☐ Has anyone in your family moved from one school district to another school district within the past three (3) years?

☐ Has anyone in your family worked, or looked for work in agriculture or farm work, logging or food processing?

For example:

Dairy Hay Poultry
Fruit or vegetable crops
Nursery/greenhouse
Timber growing
Timber harvesting
Packing apples or vegetables
Fish Farming

If your answer is "YES", then your family may be eligible for these free services.

Please provide your contact information below if you want a recruiter to visit you to find out if your family qualifies:

Parent/Guardian Name:_____

_____

Child(ren)'s Name(s):_____

_____

Address:_____

_____

_____

Phone:_____

The Cortland Migrant Education Tutorial and Support Services Program

is a federally funded program that provides a variety of services to families who have changed school districts and have worked in agriculture. This program is free to all eligible families.

***Migrant Education Services** include eligibility for free lunch, tutoring, assistance with medical expenses and special activities all year round.*

If you have any questions please contact the Cortland Migrant Education Tutorial and Support Services Program

B-105 Van Hoesen Hall
SUNY at Cortland, PO Box 2000
Cortland, New York 13045
Phone: (607) 753-4706
Toll Free: (877) 717-1945
Fax: (607) 753-4822

Or visit the Cortland METS website at www.cortland.edu/meop

Encuesta:
Hay alguien en su familia elegible para Servicios de Educación Migrante?

☐ Se ha movido alguien en su familia de un distrito escolar a otro distrito dentro de los pasados tres (3) años?

☐ Alguien en su familia ha trabajado o buscado trabajo en agricultura o en una granja, tala de árboles o procesadora de alimentos?
Por ejemplo:

Lechería Heno Avicultura
Cosechas de frutas y vegetales
Vivero/Invernadero
Crecimiento de Madera
Extracción de Madera
Empaque de manzanas o vegetales
Piscicultura

Si su respuesta es "SI", entonces su familia puede ser elegible para estos servicios gratis.

Por favor provea su información de contacto abajo si usted quiere que un reclutador lo visite para saber si su familia califica:

Padre/Guardián
Nombre:_____

_____

Niño(s)
Nombre(s):_____

_____

Dirección:_____

_____

_____

Teléfono:_____

El Programa de Servicios de Apoyo y Tutoría para la Educación Migrante de Cortland

Es un programa presupuestado federalmente que provee una variedad de servicios a las familias que han cambiado de distritos escolares y han trabajado en agricultura. Este programa es gratis para todas las familias elegibles.

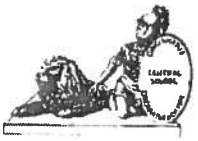
Los Servicios de Educación Migrante *incluyen elegibilidad para almuerzo gratis, tutoría, asistencia con gastos médicos y actividades especiales todo el año.*

Si usted tiene algunas preguntas por favor contacte al Programa de Servicios de Apoyo y Tutoría para la Educación Migrante de Cortland

B-105 Van Hoesen Hall
SUNY en Cortland, PO Box 2000
Cortland, New York 13045
Teléfono: (607) 753-4706
Teléfono gratis: (877) 717-1945
Fax: (607) 753-4822

O visite la página de internet del METS de Cortland
www.cortland.edu/meop

Ramona Luettger
Director of Special Education



2809 Cincinnatus Road
Cincinnatus, NY 13040

Cincinnatus Central School
607.863.3200/fax 607.863.4148
rluettger@cc.cnyric.org

Rights Regarding Referral and Evaluation for Special Education Services

Dear Parent/Guardian:

The purpose of this notice is to inform you, in writing, of your rights with regard to a child's referral for evaluation and services through Special Education.

The Cincinnatus Central School District employs numerous methods to monitor student progress in classroom programs. When intervention strategies do not result in adequate progress, the Committee on Special Education may request consent to conduct an educational evaluation to determine if special education services are necessary. As a parent/gaurdian, you also have the right to request an educational evaluation through the Committee on Special Education.

New York State Education Department clearly outlines processes and procedures created to protect the rights of students who require assistance through special education services. This information is available in English and Spanish and can be accessed from department websites listed below:

http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm (English version)
http://www.p12.nysed.gov/specialed/publications/policy/spanishparentguide.htm (Spanish translation)

You can also access the information through the Cincinnatus Central School website in the resources section of the special education department link. Printed copies are available upon request from the district Special Education Office. If you have any questions, please feel free to contact me.

Sincerely,

Ramona Luettger
Director of Special Education
Cincinnatus Central School

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached

☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached

☐ Yes, indicate type ☐ Type:_____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results:_____Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 µg/dL			

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ 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

Name:	DOB:

SCREENINGS

Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

Cincinnatus Central School Student Health Information

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone: _____

Medical Doctor Name: _____ Phone: _____

Last School Attended: _____ Phone: _____

History of Illness: Indicate year in which child had any of the following:

Anemia _____	Heat Disease _____	Scarlet Fever _____	Rheumatic Fever _____
Measles _____	Mumps _____	German Measles _____	Hepatitis _____
Tuberculosis _____	Chicken Pox _____	Pneumonia _____	Chest X-ray _____
Diabetes _____	Epilepsy _____	Whooping Cough _____	Kidney/urine Problems _____
Serious Injury _____	Operations _____	Sore Throat _____	Ear Conditions/Tubes _____
Frequent colds _____	Skin Conditions _____	Asthma _____	Concussion/head injury _____

Allergic to: (please check: ☐ Bee stings ☐ Medication ☐ Food ☐ Environmental Please Specify: _____

_____

Please provide a copy of your child immunizations. Proof of immunizations are due within 14 days of enrollment. Failure to do so, may result in exclusion until the proper documentation is received.

Date of last physical exam: (Mo/Day/Yr): _____ A copy of a NYS Physical Exam must be received by the School Health Office within 30 days of enrollment.

Does your child take any medication? If so, please provide name and dosage. _____

_____

Please describe any current medical conditions or other concerns: _____

_____

Has your child ever had a head injury where he/she lost consciousness? ☐ Yes ☐ No

After the injury sis the child experience problems such as: difficult concentrating, remembering, reading, writing, calculating, poor judgment, changes in behavior, etc? (Please Explain) _____

_____

Does the child have any other significant illnesses/restrictions? _____

_____

Complete the following for incoming Pre-Kindergarten and Kindergarten students ONLY

Any unusual circumstances during pregnancy or birth? Please specify problem: _____

Birth weight: _____ Caesarian Section: _____ Prolonged Labor _____

At what age did you child: Sit up _____ Crawl _____ Feed Self _____ Talk _____ Toilet Trained _____

☐ Right Handed ☐ Left Handed

Does you child have any special fears or habits? _____

_____

Has your child eve been hospitalized overnight? (why) _____

_____

_____ _____ _____

Parent/Guardian Signature Date Relationship to Student

CINCINNATUS CENTRAL SCHOOL
TRANSPORTATION INFORMATION FORM

** Please use HOME information – Not care giver **

Student name: _____ DOB_____ Grade____
_____ DOB_____ Grade____
_____ DOB_____ Grade____
_____ DOB_____ Grade____

Parent/ Guardian_____
Home Phone# _____ Cell# _____

RESIDENCE

House # _____ Road name _____
Township_____ County _____

DESCRIPTION OF HOUSE

(Example: color of house, landmark, distance from road, previous owner)

_____
_____
_____
_____

ADDITIONAL COMMENTS

_____
_____

Parent/Guardian Signature _____

For office use only:

Route # _____ Teacher _____
Start Date _____ am / pm Room# _____

Letter to Parents for School Meal Programs

Dear Parent/Guardian:

Children need healthy meals to learn. **Cincinnataus Central School District** offers healthy meals every school day. **Breakfast costs 1.35; lunch costs $2.15 Elementary School, $2.25 Jr/Sr. High School.** Your children may qualify for free meals or for reduced price meals. **Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals at no charge.**

1. DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD? No. Complete the application to apply for free or reduced price meals. *Use one Free and Reduced Price School Meals Application for all students in your household.* We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to: **[name, address, phone number]**.
2. WHO CAN GET FREE MEALS? All children in households receiving benefits from **SNAP, the Food Distribution Program on Indian Reservations** or **TANF**, can get free meals regardless of your income. Categorical eligibility for free meal benefits is extended to all children in a household when the application lists an Assistance Program's case number for any household member. Also, your children can get free meals if your household's gross income is within the free limits on the Federal Income Eligibility Guidelines. Households with children who are categorically eligible through an Other Source Categorically Eligible designation, as defined by law, may be eligible for free benefits and should contact the SFA for assistance in receiving benefits.
3. CAN FOSTER CHILDREN GET FREE MEALS? Yes, foster children that are under the legal responsibility of a foster care agency or court, are eligible for free meals. Any foster child in the household is eligible for free meals regardless of income. Foster children may also be included as a member of the foster family if the foster family chooses to also apply for benefits for other children. Including children in foster care as household members may help other children in the household qualify for benefits. If non-foster children in a foster family are not eligible for free or reduced price meal benefits, an eligible foster child will still receive free benefits.
4. CAN HOMELESS, RUNAWAY, AND MIGRANT CHILDREN GET FREE MEALS? Yes, children who meet the definition of homeless, runaway, or migrant qualify for free meals. If you haven't been told your children will get free meals, please call or e-mail **Troy Bilodeau, 2809 Cincinnatus Road, Cincinnatus, NY, 13040, (607) 863-3200, tbilodeau@cc.cnyric.org** to see if they qualify.
5. WHO CAN GET REDUCED PRICE MEALS? Your children may be approved as reduced price eligible if your household income is within the reduced-price limits on the Federal Eligibility Income Chart, shown on this letter. Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals at no charge.
6. SHOULD I FILL OUT AN APPLICATION IF I RECEIVED A LETTER THIS SCHOOL YEAR SAYING MY CHILDREN ARE APPROVED FOR FREE MEALS? Please read the letter you got carefully and follow the instructions. Call the school at **607-863-3200** if you have questions.
7. MY CHILD'S APPLICATION WAS APPROVED LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE? Yes. Your child's application is only good for that school year and for up to the first 30 operating days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.
8. I GET WIC. CAN MY CHILD(REN) GET FREE MEALS? Children in households participating in WIC may be eligible for free or reduced price meals. Please fill out a FREE/REDUCED PRICE MEAL application.
9. WILL THE INFORMATION I GIVE BE CHECKED? Yes and we may also ask you to send written proof.
10. IF I DON'T QUALIFY NOW, MAY I APPLY LATER? Yes, you may apply at any time during the school year. For example, children with a parent or guardian who becomes unemployed may become eligible for free and reduced price meals if the household income drops below the income limit.
11. WHAT IF I DISAGREE WITH THE SCHOOL'S DECISION ABOUT MY APPLICATION? You should talk to school officials. You also may ask for a hearing by calling or writing to: **Troy Bilodeau, 2809 Cincinnatus Road, Cincinnatus, NY, 13040, (607) 863-3200, tbilodeau@cc.cnyric.org**
12. MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN? Yes. You or your child(ren) do not have to be U.S. citizens to qualify for free or reduced price meals.
13. WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD? You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you. If you live with other people who are economically independent (for example, people who you do not support, who do not share income with you or your children, and who pay a pro-rated share of expenses), do not include them.
14. WHAT IF MY INCOME IS NOT ALWAYS THE SAME? List the amount that you normally receive. For example, if you normally make $1000 each month, but you missed some work last month and only made $900, put down that you made $1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.
15. WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME? If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
16. MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS HER COMBAT PAY COUNTED AS INCOME? No, if the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your school for more information.
17. MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR? To find out how to apply for **SNAP** or other assistance benefits, contact your local assistance office or call **1-800-342-3009**.

2019-2020 INCOME ELIGIBILITY GUIDELINES FOR FREE AND REDUCED PRICE MEALS OR FREE MILK

REDUCED PRICE ELIGIBILITY INCOME CHART

Total Family Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$ 23,107	$ 1,926	$ 963	$ 889	$ 445
2	$ 31,284	$ 2,607	$ 1,304	$ 1,204	$ 602
3	$ 39,461	$ 3,289	$ 1,645	$ 1,518	$ 759
4	$ 47,638	$ 3,970	$ 1,985	$ 1,833	$ 917
5	$ 55,815	$ 4,652	$ 2,326	$ 2,147	$ 1,074
6	$ 63,992	$ 5,333	$ 2,667	$ 2,462	$ 1,231
7	$ 72,169	$ 6,015	$ 3,008	$ 2,776	$ 1,388
8	$ 80,346	$ 6,696	$ 3,348	$ 3,091	$ 1,546
*Each Add'l person add	$ 8,177	$ 682	$ 341	$ 315	$ 158

How to Apply: To get free or reduced price meals for your children carefully complete one application following the instructions for your household and return it to the designated office listed on the application. If you now receive SNAP, Temporary Assistance to Needy Families (TANF) for any children or participate in the Food Distribution Program on Indian Reservations (FDPIR), the application must include the children's names, the household SNAP, TANF or FDPIR case number and the signature of an adult household member. All children should be listed on the same application. If you do not list a SNAP, TANF or FDPIR case number for any household member, the application must include the names of everyone in the household, the amount of income each household member, and how often it is received and where it comes from. It must include the signature of an adult household member and the last four digits of that adult's social security number, or check the box if the adult does not have a social security number. **An application for free and reduced price benefits cannot be approved unless complete eligibility information is submitted, as indicated on the application and in the instructions.** Contact your local Department of Social Services for your SNAP or TANF case number or complete the income portion of the application. No application is necessary if the household was notified by the SFA their children have been directly certified. If the household is not sure if their children have been directly certified, the household should contact the school.

Reporting Changes: The benefits that you are approved for at the time of application are effective for the entire school year and up to 30 operating days into the new school year (or until a new eligibility determination is made, whichever comes first). You no longer need to report changes for an increase in income or decrease in household size, or if you no longer receive SNAP.

Income Exclusions: 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 Development (Block Grant) Fund should not be considered as income for this program.

Reduced Price Eligible Students: **Beginning July 1, 2019, students in New York State that are approved for reduced price meals will receive breakfast and lunch meals at no charge.**

In the operation of child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age or disability

Meal Service to Children With Disabilities: Federal regulations require schools and institutions to serve meals at no extra charge to children with a disability which may restrict their diet. A student with a disability is defined in 7CFR Part 15b.3 of Federal regulations, as one who has a physical or mental impairment which substantially limits one or more major life activities of such individual, a record of such an impairment or being regarded as having such an impairment. Major life activities include but are not limited to: functions such as caring for one's self, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. You must request meal modifications from the school and provide the school with medical statement from a State licensed healthcare professional. If you believe your child needs substitutions because of a disability, please get in touch with us for further information, as there is specific information that the medical statement must contain.

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.

Reapplication: You may apply for benefits any time during the school year. Also, if you are not eligible now, but during the school year become unemployed, have a decrease in household income, or an increase in family size you may request and complete an application at that time.

The disclosure of eligibility information not specifically authorized by the NSLA requires a written consent statement from the parent/guardian. We will let you know when your application is approved or denied.

Sincerely,
Wendy Swift
Food Service Director

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Date Withdrew_____ F___R___D___

2019-2020 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call ***(607-863-3200)***, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Cincinnatus Food Service Department**
2809 Cincinnatus Road **or email:**
Cincinnatus, NY 13040 **gbilodeau@cc.cmyric.org**

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

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income.** For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

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
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
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 will get 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: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more) : ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

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 Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official_____ **Date Notice Sent:**_____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to Greg Bilodeau 2809 Cincinnatus Rd, Cincinnatus, NY 13040.
If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: 315-218-2176. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

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

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

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

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people 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.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.