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
  • State or other government issued ID
  • School photo ID with date of birth
  • Consulate identification card
  • Hospital or health records
  • Military dependent ID card
  • Documents issued by federal, state or local agencies
  • Court orders or another court-issued document
  • Native American tribal document
  • Records from non-profit international aid agencies and voluntary agencies

➢ **Immunization Record**

➢ **Proof of Residency**
  • Pay stub
  • Income tax form
  • Deed or lease to house or apartment
  • Utility or other bills sent to the student’s home address
  • Membership documents – such as library cards – based upon residency
  • Voter registration document
  • Official driver’s license, learner’s permit or non-driver ID
  • State or other government issued ID

➢ **Completed Registration Packet**

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

Please call (607) 863.3200, option 1, with any questions.

Office hours are from 8am-3pm during the school year.
  8am – 2pm during the summer.
Cincinnatus Central School
UPK – 12 Registration Form

Student Information

Full Name ________________________________

Street Address ____________________________________________ County __________________

Gender □ Male  □ Female

Date of Birth:  Month ___  Day ___  Year ________  Place of Birth: __________________________

Ethnicity:      Hispanic, Latino or of Spanish origin?  Yes  No

Race:  Check all that apply

□ American Indian or Alaskan Native
□ Asian
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White

Student lives with □ Both Parents  □ Father  □ Mother  □ Legal Guardian  □ Foster Parents

Registration Information

Anticipated Start Date ____________________________  Entering Grade __________________________

Has this student ever attended Cincinnatus? □ Yes  □ No  When? __________________________

Last School Attended
Address ____________________________________________
Phone ____________________________________________  Fax __________________________

Special Services

Is this student receiving any of the following:

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


Contact Information

Primary Parent/Guardian

Name ____________________________ Relationship to Child ____________________________

Mailing address ________________________________________________________________

Home Phone ____________________________ Email ____________________________

Cell Phone ____________________________ Work Phone ____________________________

Date moved in to present address: Month _____ Day _____ Year _____

Do you have legal custody of this student? [ ] Yes [ ] No

Is this student homeless? [ ] Yes [ ] No

Is this student a foster child? [ ] Yes [ ] No

Dominant language spoke in the home? [ ] English [ ] Other

Additional Parent/Guardian

Name ____________________________ Relationship to Child ____________________________

Mailing address ________________________________________________________________

Home Phone ____________________________ Email ____________________________

Cell Phone ____________________________ Work Phone ____________________________

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parent/Guardian Signature ____________________________ Date __________ Relationship to Student __________
Cincinnatus Central School
2809 Cincinnatus Road
Cincinnatus, New York 13040
(607) 863-3200

Records Request Form

Date: ______________________

Name of School transferring from ________________________________
Address ________________________________________________________
Phone Number _________________________________________________
Fax Number __________________________

The following student(s) has/have registered in the Cincinnatus School District:

<table>
<thead>
<tr>
<th>Name</th>
<th>Grade</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____________________</td>
<td>____</td>
<td>_____________</td>
</tr>
<tr>
<td>_____________________</td>
<td>____</td>
<td>_____________</td>
</tr>
<tr>
<td>_____________________</td>
<td>____</td>
<td>_____________</td>
</tr>
</tbody>
</table>

Name of Parent/Guardian (please print) ____________________________________________________________

Signature of Parent/Guardian _________________________________________________________________

Please send any and all academic, Committee on Special Education, psychological and health records including immunizations and physical, birth certificate, attendance and discipline records to:

Cincinnatus Central School District
ATTN: Registration
2809 Cincinnatus Road
Cincinnatus, NY 13040
Or Fax to: 607.863.3094

According to the Final Regulations – Family Education Rights and Privacy Act (Buckley Act), dated June 17, 1977, it is no longer necessary to obtain written consent to release records between schools. It states that school officials, including teachers within the educational institution and officials of other schools in school systems in which they intend to enroll, may receive a student’s records without written consent for such release.

Thank you in advance for your expediency in forwarding this student’s records.
HUOSSING QUESTIONNAIRE

Name of LEA: ____________________________________________________________

Name of School: ________________________________________________________

Name of Student: ________________________________________________________

   Last             First             Middle

Gender: ☐ Male           Date of Birth: _____ / _____ / _____    Grade: _____    ID#: __________
☐ Female

   Month    Day    Year

(preschool-12)  (optional)

Address: ________________________________    Phone: ____________________________

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

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

☐ In a shelter
☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as “doubled-up”)
☐ In a hotel/motel
☐ In a car, park, bus, train, or campground
☐ 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 ____________________________

Rev. 11/15/16
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 INFORMATION

<table>
<thead>
<tr>
<th>Student Last Name</th>
<th>First</th>
<th>Mid Initial</th>
<th>Birthdate / /</th>
<th>Grade</th>
<th>Sex M F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Address</td>
<td>Mailing Address (if different)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Student Lives With</td>
<td>Student Lives With</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PARENT/GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>Primary Parent/Guardian Last Name</th>
<th>First</th>
<th>Home Phone</th>
<th>Relation to Student:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Cell Phone</td>
<td>Authorized to Pick Up? Y N</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Employer</td>
<td>Email</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Parent/Guardian Last Name</th>
<th>First</th>
<th>Home Phone</th>
<th>Relation to Student:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Cell Phone</td>
<td>Authorized to Pick Up? Y N</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>Work Phone</td>
</tr>
<tr>
<td>Employer</td>
<td>Email</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Alternate Person(s) to contact in the event parent is not available

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Authorized to Pick Up Y N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Relationship</td>
<td>Home Phone</td>
<td>Work Phone</td>
<td>Cell Phone</td>
<td>Authorized to Pick Up Y N</td>
</tr>
</tbody>
</table>

Primary Doctor: ____________________________ Phone: ____________________________

List any special health conditions, allergies or daily medications:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

Parent/Guardian Signature ____________________________ Date ____________

Parent/Guardian Signature ____________________________ Date ____________
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.

Home Language Questionnaire (HLQ)

Please write clearly when completing this section

**Student Name:**

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
</table>

**Date of Birth:**

| Month | Day | Year |

**Gender:**

- [ ] Male
- [ ] Female

**Parent/Person in Parental Relation Info:**

| Last Name | First Name | Relation to Student |

**Home Language Code**

<table>
<thead>
<tr>
<th>Language Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please check all that apply.)</td>
</tr>
</tbody>
</table>

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
- [ ] 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:**

<table>
<thead>
<tr>
<th>School District Information:</th>
</tr>
</thead>
</table>

| Student ID Number in NYS Student Information System: |

<table>
<thead>
<tr>
<th>School District Information:</th>
</tr>
</thead>
</table>

| Student ID Number in NYS Student Information System: |

<table>
<thead>
<tr>
<th>School District Information:</th>
</tr>
</thead>
</table>

| Student ID Number in NYS Student Information System: |

**Address:**

---

ENGLISH
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.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☑</td>
<td>☑</td>
</tr>
</tbody>
</table>

*If yes, please explain:______________________________

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:______________________________

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**

<table>
<thead>
<tr>
<th>NAME: ____________________________</th>
<th>POSITION: ____________________________</th>
</tr>
</thead>
</table>

If an interpreter is provided, list name, position and credentials: ______________________________________________________

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

<table>
<thead>
<tr>
<th>NAME: ____________________________</th>
<th>POSITION: ____________________________</th>
</tr>
</thead>
</table>

Oral Interview Necessary: ☐ No  ☑ Yes

**DATE OF INDIVIDUAL INTERVIEW:**

<table>
<thead>
<tr>
<th>MD</th>
<th>DAY</th>
<th>YR</th>
</tr>
</thead>
</table>

Outcome of Individual Interview:  ☐ ADMINISTER NYSITELL ☐ ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM

**NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL**

<table>
<thead>
<tr>
<th>NAME: ____________________________</th>
<th>POSITION: ____________________________</th>
</tr>
</thead>
</table>

Date of NYSITELL Administration: ____________________________

<table>
<thead>
<tr>
<th>PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ENTERING  ☐ EMERGING  ☐ TRANSITIONING  ☐ EXPANDING  ☐ COMMANDING</td>
</tr>
</tbody>
</table>

For students with disabilities, list accommodations, if any, administered in accordance with IEP pursuant to CSE recommendation: ____________________________
NEW YORK STATE MIGRANT EDUCATION PROGRAM
IDENTIFICATION & RECRUITMENT OFFICE
PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Every Student Succeeds Act (ESSA). 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 lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Have you or has someone in your family worked on a farm?
   Have you moved during the past three 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 answer YES, please provide your contact information below:

Parent/Guardian Name: ________________________________________________

Home address: __________________________________________ City/Town________________________

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) 753 - 4622 or mail to Cortland Migrant Education Program,
SUNY Cortland, B-105 Van Hoesen Hall, Cortland NY 13045
El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Ley Cada Estudiante Triunfa (ESSA). 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, 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 alguien en su familia ha trabajado en la agricultura?

☐ 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, empaquetando, lavando o cortando vegetales, frutas o carnes.

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

Nombre del Padre/Encargado: ____________________________

Dirección Física: ____________________________ Ciudad ____________________________

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 (607) 753 - 4822 o por correo a Cortland Migrant Education Program, SUNY Cortland, B-105 Van Hoeseen Hall, Cortland NY 13045
Cincinnatus Central School

Bridgitte Cook Director of Pupil Personnel Services (bcook@cc.cnyric.org)
2809 Cincinnatus Road Cincinnatus, NY 13040
607.863.3200/ fax 607.863.4148

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/guardian, 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:


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,

Bridgitte Cook
Director of Pupil Personnel Services 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**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex: □M □F</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Grade:</td>
<td>Exam Date:</td>
</tr>
</tbody>
</table>

**HEALTH HISTORY**

<table>
<thead>
<tr>
<th>Allergies □No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Anaphylaxis Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Food □ Insects □ Latex □ Medication □ Environmental</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asthma □No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Asthma Care Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Intermittent □ Persistent □ Other:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seizures □No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Seizure Care Plan Attached</th>
</tr>
</thead>
</table>
| □ Yes, indicate type | □ Type: ___________________________ | Date of last seizure: _______

<table>
<thead>
<tr>
<th>Diabetes □No</th>
<th>□ Medication/Treatment Order Attached</th>
<th>□ Diabetes Medical Mgmt. Plan Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes, indicate type</td>
<td>□ Type 1 □ Type 2 □ HbA1c results: __________</td>
<td>Date Drawn: __________</td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>BMI ____________________ kg/m²</th>
<th>Percentile (Weight Status Category): □ &lt;5th □ 5th-49th □ 50th-84th □ 85th-94th □ 95th-98th □ 99th and&gt;</th>
</tr>
</thead>
</table>

| Hyperlipidemia: □No □Yes | Hypertension: □No □Yes |

**PHYSICAL EXAMINATION/ASSESSMENT**

<table>
<thead>
<tr>
<th>TESTS</th>
<th>Positive</th>
<th>Negative</th>
<th>Date</th>
<th>Other Pertinent Medical Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Screen/PRN</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Level Required Grades Pre-K &amp; K</td>
<td>Date</td>
<td>□ Concussion – Last Occurrence:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Test Done □ Lead Elevated &gt; 10 µg/dL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

□ 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**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Right</th>
<th>Left</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Acuity</td>
<td>20/</td>
<td>20/</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Distance Acuity With Lenses</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Near Vision</td>
<td>20/</td>
<td>20/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision – Color</td>
<td></td>
<td></td>
<td>□ Pass</td>
<td>□ Fail</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Right dB</th>
<th>Left dB</th>
<th>Referral</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pure Tone Screening</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Scoliosis Required for boys grade 9</td>
<td>Negative</td>
<td>Positive</td>
<td>Referral</td>
<td></td>
</tr>
<tr>
<td>And girls grades 5 &amp; 7</td>
<td></td>
<td>□</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Deviation Degree:  

Trunk Rotation Angle:  

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

□ Full Activity without restrictions including Physical Education and Athletics.

□ Restrictions/Adaptations  

□ No Contact Sports  

Use the Interscholastic Sports Categories (below) for Restrictions or modifications  

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, 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?** ___________________________

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### 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 your child have any special fears or habits?** ___________________________

**Has your child ever been hospitalized overnight? (why)** ___________________________

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**Parent/Guardian Signature** ___________________________  **Date** ___________________________  **Relationship to Student** ___________________________
CINCIENNATUS CENTRAL SCHOOL
TRANSPORTATION INFORMATION FORM
** Please use HOME information – NOT caregiver **

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 # ___________ AM/PM Teacher __________________________
Start Date _________ AM/PM Room # ________________________