Cincinnatus Central School
2809 Cincinnatus Road
Cincinnatus, NY 13040
(607) 863-3200
Fax (607) 863-3023

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 Student Registration Form

Child's name: _____ _____ _____
Last First Middle

Child's address: _____ **County:** _____

Child resides with: _____

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 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 ☐ **or NO, not Hispanic** ☐

Select one or more races from the following five racial groups. Check all groups that apply to your 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, Samoa, 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 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**

Homeless information

The definition of *homeless* is per Education Law §3209 and 100.2(x) of the Regulations of the Commissioner of Education and the McKinney-Vento Homeless Education Assistance Act (42 USC. Sections 11431 et seq), (McKinney-Vento Act) or one of the following:

- A migratory child who qualifies as homeless because he or she is living in circumstances as described below.
- An unaccompanied youth is a homeless child for whom no parent or person in parental relations is available. (8 NYCRR §100.2[x][1].
- (42 USC §11434a [2]; Education Law §3209 [1][a]; 8 NYCRR §100.2[x][1].

Except as otherwise proved by law, a homeless child is a child who does not have a fixed, regular, and adequate nighttime residence or whose primary nighttime location is in a public or private shelter designated to provide temporary living accommodations, or a place not designed for, or ordinarily used as, regular sleeping accommodations for human beings. This definition includes a child who is:

- sharing the housing of relatives or other persons due to loss of housing, economic hardship or similar reason (sometimes referred to as doubled-up);
- living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations;
- living in a car, park, public space, abandoned building, substandard housing, bus or train stations or similar settings;
- abandoned in hospitals;
- temporarily housed in a shelter awaiting foster care placement

Please indicate where the child is staying: _____

For Office Use Only **Date Received**_____

Student # _____ **BC** _____ **SS** _____ **#2999** _____ **Start Date:** _____

Bus Route _____

Proof of Residency _____

Immunizations Due: _____ **Physical Due:** _____

Placement: _____ **Administrator's Signature:** _____

CINCINNATUS CENTRAL SCHOOL
STUDENT DATA CARD

(Please Print)

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

Physical address Street:

City: State: ZIP Code:

Student Lives With:

Mailing Address Street (if different from Physical Address):

City: State: ZIP Code:

Student Lives With:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Last Name: First:

Parent/Guardian Address Street:

City: State: ZIP Code:

Employer:

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Email:

Relation to Student: _____

Authorized to Pickup? ☐ Yes ☐ No

Custody? ☐ Yes ☐ No

Parent/Guardian Last Name: First:

Parent/Guardian Address Street:

City: State: ZIP Code:

Employer:

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Email:

Relation to Student: _____

Authorized to Pickup? ☐ Yes ☐ No

Custody? ☐ Yes ☐ No

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: _____

The Migrant Education Outreach Program

…is a federally funded program that provides a variety of services to families who work in agriculture. This program is **free** to all eligible families and includes education assistance, assistance with medical expenses, free lunch programs and special activities all year round. Participation is voluntary, and a family may choose what serves them best. The program is for students from migrant (**meaning families who have moved from one school district to another within the past 3 years regardless of their nationality**) and either the worker or worker's children are under age 22 or the student or parent has performed temporary or seasonal farm work. If you would take a few minutes to complete this questionnaire it might help us locate prospective students eligible for the program.

1. Has anyone in your family **worked, or looked for work** at the following occupations within the last three (3) years:

Please indicate the activities that apply to your family.

Any agricultural or farm work (such as hay, dairy, fruit or vegetable crops, poultry, fish farming, nursery/greenhouse, other)?

Work related to logging, timber growing or harvesting?

Work at food processing plant, (such as vegetable or poultry processing plants packing apples or vegtables)?

If you checked any of the activities under question 1, you may be eligible for services.

If you would like a program recruiter to call,
Please provide contact information below

Parent/Guardian/Eligible Person's Name_____

Children's' names (and ages) _____

_____

Address_____

Home Phone_____ If no phone, how can we contact you?

Name of school where your children attend?_____

Please mail this form or you can also call The Migrant Office @SUNY CORTLAND B 105 VANHOESEN HALL CORTLAND, NY 13045
877-717-1945

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

Please print or type clearly

DISTRICT

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: ❑ Possible LEP ❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ English ❑ Other _____ *specify*

2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ English ❑ Other _____ *specify*

3. What language(s) does the student understand? ❑ English ❑ Other _____ *specify*

4. What language(s) does the student speak? ❑ English ❑ Other _____ *specify*

5. What language(s) does the student read? ❑ English ❑ Other _____ *specify* ❑ Does Not Read

6. What language(s) does the student write? ❑ English ❑ Other _____ *specify* ❑ Does Not Write

7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

Signature of Parent/Guardian/Other

Month: Day: Year:

Date

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

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
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type:_____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ 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:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code

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
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# _____