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

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 **one** box.*)

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

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

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

_____
Date

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:

Month *Day* *Year*

GENDER:
❑ 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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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

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:

http://www.p12.11ysed.gov/specialed/publications/policy/parentguide.htm (English version)
http://www.p12.nysed.gov/specialed/publications/policy/spanisliparentguide.htin (Spanish translation)
Hube

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

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

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:

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# _____