



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

Welcome to Cincinnati 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.

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 <input type="checkbox"/> | Remedial Math <input type="checkbox"/> | Speech <input type="checkbox"/> |
| Physical Therapy <input type="checkbox"/> | Occupational Therapy <input type="checkbox"/> | Other <input type="checkbox"/> |
| Remedial Reading <input type="checkbox"/> | Academic Enrichment Program <input type="checkbox"/> | IEP/504 <input type="checkbox"/> |

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 Cincinnati: 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: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
City:	State:	ZIP Code:	Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:		Work Phone: () -	
		Email:	

Parent/Guardian Last Name:	First:	Home Phone: () -	Relation to Student: _____
Parent/Guardian Address Street:		Cell Phone: () -	Authorized to Pickup? <input type="checkbox"/> Yes <input type="checkbox"/> No
City:	State:	ZIP Code:	Custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:		Work Phone: () -	
		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: _____

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 vegetables)?

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**



Home Language Questionnaire (HLQ)

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT _____ *Please print or type clearly*

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

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

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ *specify*
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ *specify*
- What language(s) does the student understand? English Other _____ *specify*
- What language(s) does the student speak? English Other _____ *specify*
- What language(s) does the student read? English Other _____ *specify* Does Not Read
- 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?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other _____

Date _____

Month: _____ Day: _____ Year: _____

Cincinnati 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 _____ Hepatitis _____
 Tuberculosis _____ Chicken Pox _____ Pneumonia _____ Chest X-ray _____
 Diabetes _____ Epilepsy _____ Whooping _____ Kidney/urine Problems _____
 Serious Injury _____ Operations _____ Cough _____ 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 did 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 your child have any special fears or habits? _____

 Has your child ever 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: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> 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	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K		Date		<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____
<input type="checkbox"/> Additional Information Attached		

Name:	DOB:
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SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis <small>Required for boys grade 9 And girls grades 5 & 7</small>	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> 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: <i>(please print)</i>	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# _____