



## CINCINNATUS CENTRAL SCHOOL DISTRICT

Todd Freeman, Superintendent of Schools  
2809 Cincinnatus Road, Cincinnatus, NY 13040  
Telephone: (607) 863-4069 Fax: (607) 863-4109

**Amanda Graham-Quirk**  
Business Official  
(607) 863-3200 Ext. 7...2

**David Phetteplace**  
Secondary Principal  
(607) 863-3200 Ext. 5

**Kimberly Symons**  
Elementary Principal  
(607) 863-3200 Ext. 4

**Bridgitte Cook**  
Director of Pupil  
Personnel Services  
(607) 863-3200 Ext. 6

**Michael Stafford**  
Director of Facilities  
(607) 863-3200 Ext. 7...6

**Carolyn Nowalk**  
Personnel Clerk  
(607) 863-3200 Ext. 7...3

**Melissia Custer**  
Athletic Director  
(607) 863-3200 Ext. 7...4

**Deborah Lilley**  
Head Bus Driver  
(607) 863-3866

**Gregory Bilodeau**  
Cafeteria Manager  
(607) 863-3200 Ext. 7...5

**Megan Potter**  
School Nurse  
(607) 863-3200 Ext. 2

**Katy Denkenberger**  
Treasurer  
(607) 863-3200 Ext. 7...2

We are thrilled to welcome you to Cincinnatus Central School District!

Included in this packet are several documents we need to register new students:

- Registration Form
- Record Request Form
- Housing Questionnaire
- Program Support Services
- Student Data Card
- Home Language Questionnaire
- New York State Migrant Education Program Survey
- New York State School Health Examination Form
- Transportation Information Form

In addition to the forms listed above, please present the following documents:

- Birth Certificate for each registrant
- Proof of Residency
- Immunization Record
- Existing custody agreements / court orders

If you have any questions regarding any aspect of your start to the District, please connect with the appropriate staff member to help you.

Again, welcome to Cincy!

# Cincinnatus Central School

## UPK – 12 Registration Form

### Student Information

Full Name					
Street Address				County	
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Date of Birth:	Month	Day	Year	Place of Birth:	
Ethnicity:	Hispanic, Latino or of Spanish origin?	Yes	No		
Race:	Check all that apply				
	<input type="checkbox"/> American Indian or Alaskan Native				
	<input type="checkbox"/> Asian				
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander				
	<input type="checkbox"/> Black or African American				
	<input type="checkbox"/> White				
Student lives with	<input type="checkbox"/> Both Parents	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Foster Parents

### Registration Information

Anticipated Start Date		Entering Grade	
Has this student ever attended Cincinnatus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Last School Attended	_____		
Address	_____		
Phone	_____	Fax	_____

### Special Services

Is this student receiving any of the following:			
Resource Room	<input type="checkbox"/>	Remedial Math	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>
Remedial Reading	<input type="checkbox"/>	Academic Enrichment Program	<input type="checkbox"/>
		Speech	<input type="checkbox"/>
		Other	<input type="checkbox"/>
		IEP/504	<input type="checkbox"/>
_____			

## 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)

Name	Date of Birth	Grade

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Student

Kimberly Symons, Principal  
Grades UPK - 4

**Cincinnatus Central School**  
**2809 Cincinnatus Road**  
**Cincinnatus, New York 13040**  
**(607) 863-3200**

David Phetteplace, Principal  
Grades 5 – 12

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:

Name	Grade	Date of Birth
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

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 expedience in forwarding this student's records.

## HOUSING 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 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 INFORMATION

Student Last Name	First	Mid Initial	Birthdate / /	Grade	Sex M F
Physical Address			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code
Student Lives With			Student Lives With		

## PARENT/GUARDIAN INFORMATION

Primary Parent/Guardian Last Name	First	Home Phone	Relation to Student:		
Address		Cell Phone	Authorized to Pick Up?	Y	N
City	State	Zip Code	Work Phone	Custody?	Y N
Employer		Email			

Additional Parent/Guardian Last Name	First	Home Phone	Relation to Student:		
Address		Cell Phone	Authorized to Pick Up?	Y	N
City	State	Zip Code	Work Phone	Custody?	Y N
Employer		Email			

Alternate Person(s) to contact in the event parent is not available					
Name	Relationship	Home Phone	Work Phone	Cell Phone	Authorized to Pick Up
					Y N
Name	Relationship	Home Phone	Work Phone	Cell Phone	Authorized to Pick Up
					Y N

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

Elisa Alvarez, Associate 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 Person in Parental Relation:*  
*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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
		<input type="checkbox"/> Male
Month	Day	Year
<input type="checkbox"/> Female		
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

### Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<input type="checkbox"/> Guardian(s)		_____
			specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			specify

### THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT  
INFORMATION SYSTEM:

District Name (Number) & School:

Address:



## Home Language Questionnaire (HLQ)—Page Two

### Educational History

8. Indicate the total number of years that your child has been enrolled in school \_\_\_\_\_

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes\*    No    Not sure

☐
☐
☐

\*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?    ☐ Minor    ☐ Somewhat severe    ☐ Very severe

10a. Has your child ever been **referred** for a special education evaluation in the past?    ☐ No    ☐ Yes\* *\*Please complete 10b below*

10b. *\*If referred for an evaluation*, has your child ever **received** any special education services in the past?

☐
☐

No    Yes – Type of services received: \_\_\_\_\_

Age at which services received *(Please check all that apply):*

☐

Birth to 3 years (Early Intervention)

☐

3 to 5 years (Special Education)

☐

6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?    ☐ No    ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or of Person in Parental Relation*

Month:    Day:    Year:

*Date*

Relationship to student:    ☐ Parent    ☐ 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

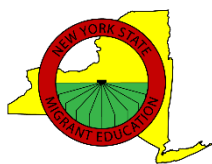
☐ TRANSITIONING

☐ EXPANDING

☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

FAXED BY \_\_\_\_\_ DISTRICT \_\_\_\_\_



## 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 \_\_\_\_\_

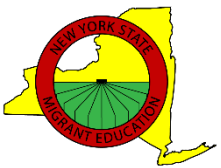
Telephone number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Best time to be reached: \_\_\_\_\_ AM/PM

Previous Address: \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Student name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

**To submit this referral, please fax to (607) 753 - 4822 or mail to Cortland Migrant Education Program,  
SUNY Cortland, B-105 Van Hoesen Hall, Cortland NY 13045**



**FAXED BY** \_\_\_\_\_

**DISTRICT** \_\_\_\_\_

## **PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE NEW YORK**

### **OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES**

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 involucramiento 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?**

**¿Se han mudado durante los últimos 3 años?**

- ☐ 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, empacando, 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 Hoesen Hall, Cortland NY 13045**

## **Cincinnatus Central School**

Bridgitte Cook Director of Pupil Personnel Services ([bcook@cc.cnyric.org](mailto:bcook@cc.cnyric.org))  
2809 Cincinnatus Road Cincinnatus, NY 13040  
Phone 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 service 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.p12.11nysed.gov/specialed/publications/policy/parentguide.htm> (English version)  
<http://www.p12.11nysed.gov/specialed/publications/policy/spanishliparent.htm> (Spanish translation)

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

Sincerely,

*Bridgitte Cook*

Bridgitte Cook, Director of Pupil Personnel Services, Cincinnatus Central School

<b>REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM</b> <b>TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR</b> <b>IF AN AREA IS NOT ASSESSED INDICATE NOT DONE</b>					
<b>Note:</b> 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).					
<b>STUDENT INFORMATION</b>					
Name				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
School:				DOB:	
				Grade:	
				Exam Date:	
<b>HEALTH HISTORY</b>					
<b>Allergies</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached			
<b>Asthma</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached			
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached		Date of last seizure: <input type="checkbox"/> Seizure Care Plan Attached	
<b>Diabetes</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached			
<b>Risk Factors for Diabetes or Pre-Diabetes:</b> <i>Consider screening for T2DM if BMI% &gt; 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.</i>					
<b>BMI</b> _____ kg/m2					
<b>Percentile (Weight Status Category):</b> <input type="checkbox"/> <5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> -49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> -84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> -94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> -98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and>					
<b>Hyperlipidemia:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done			<b>Hypertension:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done		
<b>PHYSICAL EXAMINATION/ASSESSMENT</b>					
<b>Height:</b>		<b>Weight:</b>		<b>BP:</b>	
				<b>Pulse:</b>	
				<b>Respirations:</b>	
<b>Laboratory Testing</b>		<b>Positive</b> <b>Negative</b>		<b>Date</b>	
TB- PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Sickle Cell Screen-PRN		<input type="checkbox"/>		<input type="checkbox"/>	
<b>Lead Level Required Grades Pre- K &amp; K</b>				<b>Date</b>	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$					
<input type="checkbox"/> <b>System Review and Abnormal Findings Listed Below</b>					
<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Dental		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Back/Spine	
<input type="checkbox"/> Neck		<input type="checkbox"/> Lungs		<input type="checkbox"/> Genitourinary	
				<input type="checkbox"/> Extremities	
				<input type="checkbox"/> Skin	
				<input type="checkbox"/> Neurological	
				<input type="checkbox"/> Speech	
				<input type="checkbox"/> Social Emotional	
				<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list)      ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
<b>SCREENINGS</b>					
<b>Vision</b> (w/correction if prescribed)	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Not Done</b>	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
Notes					
<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				<b>Not Done</b>	
Pure Tone Screening	<b>Right</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Left</b> <input type="checkbox"/> Pass <input type="checkbox"/> Fail	<b>Referral</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
<b>Scoliosis</b> Screen Boys in grade 9, and Girls in grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>					
<input type="checkbox"/> <b>Student may participate in all activities without restrictions.</b> <input type="checkbox"/> <b>Student is restricted from participation in:</b> <div style="margin-left: 20px;"> <input type="checkbox"/> <b>Contact Sports:</b> Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.  <input type="checkbox"/> <b>Limited Contact Sports:</b> Baseball, Fencing, Softball, and Volleyball.  <input type="checkbox"/> <b>Non-Contact Sports:</b> Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track &amp; Field.  <input type="checkbox"/> <b>Other Restrictions:</b> </div>					
<b>Developmental Stage for Athletic Placement Process <u>ONLY</u> required</b> for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level <b>OR</b> Grades 9-12 who wish to play at the modified interscholastic sports level. <b>Tanner Stage:</b> <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V      Age of First Menses (if applicable) : _____					
<input type="checkbox"/> <b>Other Accommodations*:</b> (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain.    *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
<b>MEDICATIONS</b>					
<input type="checkbox"/> <b>Order Form for Medication(s) Needed at School Attached</b>					
<b>IMMUNIZATIONS</b>					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
<b>HEALTH CARE PROVIDER</b>					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
<b>Please Return This Form To Your Child's School When Completed.</b>					

# 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 _____
		Measles _____	
Tuberculosis _____	Chicken Pox _____	Pneumonia _____	Chest X-ray _____
Diabetes _____	Epilepsy _____	Whooping _____	Kidney/urine Problems _____
		Cough _____	
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 is 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 \_\_\_\_\_

# CINCINNATUS 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)

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### ADDITIONAL COMMENTS

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Parent/Guardian Signature \_\_\_\_\_

For office use only:

Route # \_\_\_\_\_  
Start Date \_\_\_\_\_ AM/PM

Teacher \_\_\_\_\_  
Room # \_\_\_\_\_