NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT

Registration Form

For Central Registration Use Only

*Today's Date:*_____ *Student ID#*_____ *Bus: a.m.*____ *p.m.*____

*Birth Certificate:*____ *Immunization Record:*____ *Custody Order*____

*Homeless Questionnaire:*_____ *Proof of Residency:*_____

*Residency approved by:*_____ *Date:*_____
Administrator's Signature

Student Information

Legal Last Name	Legal First Name		Legal Middle Name	Gender M F
Date of Birth	Age	Grade	Place of Birth (City & State)	

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race ☐ White/Caucasian ☐ Asian ☐ Pacific Islander ☐ Black/African American ☐ American Indian

Primary Language ☐ English ☐ Spanish ☐ French ☐ Other:

Primary Household – ***Where Student Lives***

Home Phone		
Street Address	City	Zip Code
Mailing Address *(If different)*	City	Zip Code

First Adult: Relationship to child ☐ Mother ☐ Father ☐ Step-parent Other Adult:_____	First Name	Last Name

Cell Phone: Email:

Education: Select highest level completed
☐ 8th Grade or lower ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade ☐ GED ☐ Some college
☐ Vocational Degree ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

Employment, School, Job Training: Select all that apply
☐ Employed ☐ In School ☐ Job Training ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Retired
☐ Member of the U.S. Military on active duty ☐ None

Employer Name	Employer Phone

Street Address	City	Zip Code

Second Adult: Relationship to child ☐ Mother ☐ Father ☐ Step-parent Other Adult:_____	First Name	Last Name

Cell Phone: Email:

Education: Select highest level completed
☐ 8th Grade or lower ☐ 9th Grade ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade ☐ GED ☐ Some college
☐ Vocational Degree ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

Employment, School, Job Training: Select all that apply
☐ Employed ☐ In School ☐ Job Training ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Retired
☐ Member of the U.S. Military on active duty ☐ None

Employer Name	Employer Phone

Street Address	City	Zip Code

Does your family receive benefits from the Department of Social Services: ☐ Yes ☐ No
If "yes", which benefits? ☐ SNAP food stamps ☐ Medicaid ☐ Medical Assistance ☐ HEAP ☐ Public Assistance ☐ PSAP
Does your family receive WIC? ☐ Yes ☐ No ☐ Previously

Primary Household – *Cont.*

Housing Information – Select your current situation

☐ Own ☐ Rent ☐ Transitional housing – since what date? _____ ☐ Homeless – since what date?_____

☐ Shelter – Since what date? _____ ☐ Living with friends/relatives due to a fire/flood in my home – since what date? _____

During the past 12 months, I/we have moved from temporary housing to permanent housing. ☐ Yes ☐ No

Family/Household Members – List your name, the name(s) of your child(ren) and the names of all other adults and children who live in your home. Use additional paper if needed

Legal Last Name	Legal First Name	Legal Middle Name	Relationship (daughter, son, aunt, uncle, grandparent, etc.)	D.O.B. MM/DD/YYYY	Grade in school
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Family Income Information – How you provide for your family. Select each source of income that you, your husband/wife/companion/partner and all children receive.

☐ Employment ☐ Unemployment ☐ Self-Employment ☐ Social Security ☐ SSI ☐ SSD ☐ Commission

☐ Child Support ☐ Alimony ☐ Worker's Compensation ☐ Scholarship/Grant/Stipend ☐ Tips ☐ Foster Care

☐ Other Thank Guardian (OTG) ☐ Pension ☐ Retirement ☐ Rental Properties ☐ Friend/Family Member

☐ Other (specify):

Yearly Family Income – Select your income range

☐ Below $20,000 ☐ $20,000 - $35,000 ☐ $35,000 - $50,000 ☐ $50,000 - $65,000 ☐ $65,000 - $80,000

☐ $80,000 - $95,000 ☐ More than $95,000

Secondary Household – *If biological parents are separated*

Home Phone:

Street Address	City	Zip Code
Mailing Address *(If different)*	City	Zip Code

First Adult: Relationship to child ☐ Mother ☐ Father ☐ Step-parent Other Adult:_____	First Name	Last Name

Cell Phone: Email:

Place of Employment: Work Phone:

Second Adult: Relationship to child ☐ Mother ☐ Father ☐ Step-parent Other Adult:_____	First Name	Last Name

Cell Phone: Email:

Place of Employment: Work Phone:

Student Information – *Cont.*

Custodial Information – Specify who has custody of child

☐ Both Parents (shared custody) ☐ Biological Mother ☐ Biological Father Other (specify):

Custody order will be placed on file with the main office ☐ Yes ☐ No

Educational Information – Complete the questions below regarding your child

1. My child has a disability or disabilities.	☐ Yes ☐ No
If "Yes," type of disability/disabilities (list all):	
If "Yes," does your child's disability/disabilities limit his/her ability to walk, run or climb stairs?	☐ Yes ☐ No
2. My child has an IEP (Individualized Education Plan) or an IFSP (Individualized Family Service Plan).	☐ Yes ☐ No
3. My child is/will be receiving services.	☐ Yes ☐ No
If "Yes," indicate which Early Intervention Services your child is/will be receiving (select all that apply): ☐ Speech Therapy ☐ Special Instruction ☐ Physical Therapy ☐ Occupational Therapy ☐ Other (specify):	
4. I/We have had other children who attended Head Start.	☐ Yes ☐ No
If "Yes," name of child/ren:	
If "Yes," name of school(s)/location(s):	
5. I/We have had other children who attended Pre-K.	☐ Yes ☐ No
If "Yes," name of child/ren:	
If "Yes," name of school(s)/location(s):	
6. I/We have a medically fragile child (chronic illness, terminal illness, etc).	☐ Yes ☐ No
If "Yes," name of child/ren:	
7. My child was referred to a preschool program from a mental health provider.	☐ Yes ☐ No

Other Information

1. The parent/guardians in the household are under 21 years of age.	☐ Yes ☐ No
2. The child is in foster care.	☐ Yes ☐ No
3. We are a refugee family.	☐ Yes ☐ No
4. Child's mother/father is currently incarcerated.	☐ Yes ☐ No
5. I have a concern about my child. (select all that apply): ☐ Speech ☐ Hearing ☐ Behavioral ☐ Emotional ☐ Social	☐ Yes ☐ No

Signature(s)

Read the following statements and sign where indicated.

I/We have completed all sections on the registration form and certify the information is correct. I/We further understand that, if necessary, additional documents may be requested and I/we will comply with this request.

_____ _____

Signature of Primary Adult Date

_____ _____

Signature of Second Adult (if applicable) Date

NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT

Health Questionnaire

For Central Registration Use Only

*Today's Date:*_____ *Student ID#* _____

*Birth Certificate:*____ *Immunization Record:*____ *Physical Form*____

Student Information

Legal Last Name	Legal First Name		Legal Middle Name	Gender M F
Date of Birth	Age	Grade	Place of Birth (City & State)	
Child's Physician	Physician's Address & Phone Number			

Allergies

Does your child have any allergies? (Including bee stings) Yes ☐ No ☐ (Please indicate the allergy and reaction to the allergen. Such as anaphylaxis, contact rash, difficulty breathing, etc.):

1.

2.

3.

4.

Do any of these allergies require an Epi Pen? ☐ Yes ☐ No (This is considered a medication and needs to be listed below***.)

Medications

A Doctor's order is required by N.Y.S. Law in order for prescription or over-the-counter medicine to be dispensed by the school nurse. Medications must be in there original container, unexpired and clearly marked. ***Medications cannot be transported by your child under any circumstances.***

Does your child take medication at home or in school? ☐ Yes ☐ No (If yes, please complete the information below.)

Name of Medication	***Indicate home, school or both***	***Indicate dosage and frequency***
1.		
2.		
3.		
4.		

Corrective Lenses

Does your child wear corrective lenses? (Eye glasses/contacts) ☐ Yes ☐ No (If yes, please complete the information below.)

Date prescribed: Prescribed by (Physician & location):

Learning Disabilities

Please list any learning disabilities that your child may have genetically inherited by either parent. (i.e. dyslexia, color blindness, ADD, ADHD, etc.

1.

2.

3.

4.

Health Concerns
Does your child have any health concerns (including ear conditions, headaches, vision problems, etc.)? Please describe below.

Medical History		
Indicate if your child has/had any of the following medical issues. ***Give more detail below if necessary.***		
Frequent headaches	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Frequent nosebleeds	☐ Yes ☐ No	
Hearing defect	☐ Yes ☐ No	
Speech difficulty	☐ Yes ☐ No	
History of earaches or ear infections	☐ Yes ☐ No	
Eye defect	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Epilepsy	☐ Yes ☐ No	
Heart problems	☐ Yes ☐ No	
Frequent colds and/or sore throat	☐ Yes ☐ No	
Chicken pox	☐ Yes ☐ No	
Communicable disease (measles, mumps, rubella)	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	
Pneumonia	☐ Yes ☐ No	
Rheumatic fever	☐ Yes ☐ No	
Tuberculin test	☐ Yes ☐ No	
Serious injuries (Please list)	☐ Yes ☐ No	
Operations (Please list)	☐ Yes ☐ No	

Physical Handicaps
Does your child have a physical handicap? ☐ Yes ☐ No (If yes, give specific details below.)

Signature(s)	
Signature of Primary Adult	Date
Signature of Second Adult (if applicable)	Date

NORTHERN ADIRONDACK ELEMENTARY SCHOOL

PO Box 164
Ellenburg Depot, NY 12935
(518) 594-3986

Housing Questionnaire

Name of LEA: Northern Adirondack Central School

Name of School: Northern Adirondack Elementary School

Name of Student: _____
Last First Middle

Gender: ____Male ____Female **Date of Birth:** ____/____/_____ (Month Day Year) **Grade:** _____ (PK-12)

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**.)

_____In permanent housing

_____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): _____

_____ _____

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

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

Date: _____