Mechanicville City School District

25 Kniskern Avenue Mechanicville, New York 12118
Telephone 518-664-9888 Extension 2416 Fax 518-514-2108

Authorization To Request Release Of School Records

Authorization is hereby granted to the Mechanicville City School District of Mechanicville, New York to request information on the following student:

***Name of Student*_____ *Date of Birth*_____ *Grade*_____**

School Transferring From: _____

School Address: _____ _____ City, State: _____

School Telephone*: _____ School Fax #:_____

Please send the following information:

- ☐ Birth Certificate Report Card/Transcript
- ☐ Immunization/Health Records
- ☐ Custodial Documentation on File
- ☐ Special Education/AIS Records if applicable
- ☐ Attendance Records
- ☐ Standardized Test Results
- ☐ Science Lab Reports
- ☐ Exit grades up to the date student left your district

PLEASE FAX DOCUMENTATION TO 514-2108
Central Registrar Office
Mechanicville City School District
25 Kniskern Avenue
Mechanicville, NY 12118

Signature of Parent or Legal Guardian ***Date of Authorization***

_____ _____

MECHANICVILLE CITY SCHOOL DISTRICT
STUDENT REGISTRATION FORM

Student Name: _____ Student #: _____ Grade: _____

Physical Address: _____ Date of Birth: _____ Gender: Male

Street Apt. #

_____ _____ County of Residence: _____

City , State Zip

Mailing Address: _____ Home Phone Number: _____

(if other than above - ex: P.O. Boxes) Street City Zip

Special Accommodations: (please check one)

☐ Student does not have any Special Accommodations

☐ Special Education Classification

☐ Section 504 Classification

Ethnicity: **(Please check all that apply)**

☐ American Indian ☐ Black/African American

☐ Asian ☐ White/Caucasian

☐ Native Hawaiian/Other Pacific Islander

Hispanic/Latino: **(Please check one)**

☐ YES ☐ NO

Has your child(ren) ever attended Mechanicville City School District in the past? ☐ YES ☐ NO (Please check one)

LIST BOTH LEGAL PARENTS AND/OR GUARDIANS *(Step Parent – should be listed as Other Adult Living in Home)*****

Parent/Guardian (1): _____

Address: _____

(if different than student)

Email Address: _____

Place of Employment: _____

Work Phone #: _____ Cell Phone #: _____

☐ Is Primary Contact ☐ Receives Mail ☐ Receives Email ☐ Parent Portal Access ☐ Automated Emergency Notifications ☐ Pick Up Only

Parent/Guardian (2): _____

Address: _____

(if different than student)

Email Address: _____

Place of Employment: _____

Work Phone #: _____ Cell Phone #: _____

☐ Is Primary Contact ☐ Receives Mail ☐ Receives Email ☐ Parent Portal Access ☐ Automated Emergency Notifications ☐ Pick Up Only

Child Lives With: (**Please check <u>one</u>** :) ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Other (Specify)** ☐ **Foster Parents** ☐ **Homeless**

Other Adult Living in Home ***with Supervisory Jurisdiction***: _____ Relation to Child: _____

Place of Employment: _____ Work Phone#: _____ Cell Phone#: _____

☐ Receives Mail ☐ Receives Email ☐ Parent Portal Access ☐ Automated Emergency Notifications ☐ Pick Up Only

Any legal custodial restrictions? ☐ YES ☐ NO If yes, court documents required, see below

Important: The school district shall presume that either parent of a student has authority to obtain the child's release from school. However, a student shall not be release to a non-custodial parent if the district is provided with a certified copy of a legally binding instrument, such as a court order, decree of divorce, separation or custody that indicates the non-custodial parent does not have the right to obtain such a release.

PLEASE LIST ALL CHILDREN LIVING IN PRIMARY HOUSEHOLD UNDER THE AGE OF 21

Name: _____ Name: _____ Name: _____

DOB: _____ Age: _____ DOB: _____ Age: _____ DOB: _____ Age: _____

Gender: _____ Gender: _____ Gender: _____

Name: _____ Name: _____ Name: _____

DOB: _____ Age: _____ DOB: _____ Age: _____ DOB: _____ Age: _____

Gender: _____ Gender: _____ Gender: _____

In accordance with Chapter 549 of the Education Law of 1986, I am providing the following list of people to whom my child/children, upon my written authorization, may be released from the Mechanicville City School District. These people may also be contacted in the event of an emergency and I cannot be reached:

Name: _____ Address: _____ City, State Zip _____

Relationship: _____ Daytime Phone #: _____ Alternate #: _____

☐ **Receives Mail** ☐ **Receives Email** ☐**Parent Portal Access** ☐**Emergency Notification** ☐ **Pick Up Only**

Name: _____ Address: _____ City, State Zip _____

Relationship: _____ Daytime Phone #: _____ Alternate #: _____

☐ **Receives Mail** ☐ **Receives Email** ☐**Parent Portal Access** ☐**Emergency Notification** ☐ **Pick Up Only**

Parent in the Armed Forces: ☐ YES ☐ NO If Yes, Parent Name: _____

(Please Check One)

☐ Active Duty ☐ Reserves ☐ Veteran ☐ Civilian

Technology in the Home: ☐ Desktop Computer ☐ Laptop ☐ Chromebook ☐ Tablet ☐ Smart Phone ☐ Other

(Please check all that apply) Access to the Internet: ☐ None ☐ Wifi ☐ Mobile Hot Spot ☐ Cell Phone only

Physician to be called in an Emergency: _____ Phone #: _____

Preferred Hospital Choice: _____

RELEASE

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment to transport the child to a hospital emergency room/Allows school physician to complete physical examinations as required by State Law. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent Statement:

I certify that the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Mechanicville City School District.

Parent/Legal 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:			GENDER:
Month	*Day*	*Year*	☐ 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:		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 ***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:

Mechanicville City School District

25 Kniskern Avenue Mechanicville, New York 12118
Telephone 518-664-9888 Extension 2416 Fax 518-514-2108

RESIDENCY QUESTIONNAIRE FORM

Name of Student: _____

Address:_____

Phone: _____

Date of Birth: _____ _____ _____ _____ _____
Month Day Year *(preschool-12)*

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.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

Where is the student currently living? *(Please check <u>one</u> box.)*

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes refered 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

Mechanicville City School District

25 Kniskern Avenue Mechanicville, New York 12118
Telephone 518-664-9888 Extension 2416 Fax 518-514-2108

Eligibility Screen for Migrant Education Services

** Migrant Eduaction Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

1. Has your family moved to a different school district in the last 3 years? ☐ Yes ☐ No

2. In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) ☐ Yes ☐ No

3. If yes, what farm did you work on? _____ Where? _____ When? _____

If you can answer YES to BOTH of the above questions, your family MAY qualify for Migrant Education services. To be contacted by a Migrant Education liaison, please complete the information below.

Child's Name _____ D.O.B. _____ Grade_____

Child's Name _____ D.O.B. _____ Grade_____

Child's Name _____ D.O.B. _____ Grade_____

Child's Name _____ D.O.B. _____ Grade_____

Child's Name _____ D.O.B. _____ Grade_____

Parents/Guardians

Mother's Name _____ Father's Name _____

Home Street Address _____ Home Phone # _____

City, State Zip _____ Cell Phone # _____

_____ _____

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

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

_____

Date

Any questions regarding the Migrant Education Program can be directed to

Mary Alice Hipwell, Director of Student Services @ (518) 664-7336 ext. 2503.

Mechanicville City School District
TEACHER DATA SHEET

Student Information		
Student's Name:	Grade:	Date:
Student lives with: ☐ Mother & Father ☐ Mother ☐ Father ☐ Guardian/Other: _____		
Academic Information		
Names and Addresses of Previous Schools Attended (list most recent first):		
Name of School:	Phone Number:	
Address:	Previous Teacher's Name:	
	Month/Year Attended: From_____to_____	
Name of School:	Phone Number:	
Address:	Previous Teacher's Name:	
	Month/Year Attended: From_____to_____	
Has your child ever been retained: ☐ Yes ☐ No If yes, what grade?		
Does your child presently receive Special Education Services? ☐ Yes ☐ No		
Does your child have an IEP or a 504 plan? ☐ Yes ☐ No		
Have they in the past? ☐ Yes ☐ No		
Does your child presently receive Academic Intervention Services for:		
☐ Reading ☐ Math ☐ Science ☐ Social Studies		
Does your child presently receive:		
☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy		
Have they received these services in the past? ☐ Yes ☐ No		
Comments:		
Has there been a recent change in your family (parent separation, death, birth, hospitalization)? If so, please explain:		
Does your child receive counseling services? ☐ Yes ☐ No		
Comments:		

TURN OVER

General Academic Levels				
	Advanced	Average	Developing	Comments
Reading	○	○	○	
Math	○	○	○	
Writing	○	○	○	

Sibling Information					
Name (first & last)	Sex	D.O.B.	Living in the home?	Grade	School Attending

_____ _____

Parent/Guardian Signature **Date Signed**

_____

Parent/Guardian
(Please Print Name)

Mechanicville City School District

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____
Name_____Phone_____FAX_____

to release the medical records of my child, _____, DOB_____
to the district's: Medical Director, School Nurse, Athletic Trainer (AT), Counselor, Occupational, Therapist (OT), Physical Therapist (PT), Psychologist, Social Worker, Speech Therapist (ST).
❒ Other _____

The healthcare provider may disclose the following information:

Immunizations, Health Appraisals, Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy.

The Protected Health Information may be used, disclosed or received for the following purpose(s):

To develop care or therapy plans for routine and emergent school management
To design appropriate educational, school, or athletic programs
To assess the impact of the medical condition(s) on school programming and/or attendance
To share school observations/concerns surrounding behavior
To assess a medical basis for modification of transportation and/or home tutoring
Medication delivery or therapy prescriptions
At patient's request with no specified purpose
Court, Probation or CPS Mandates

PARENT:

This authorization is valid for the duration of attendance within the school district.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the School Nurse. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____

Signature of Parent/Guardian (or student if over 18) Relationship Date

Mechanicville City School District

MEDICAL HISTORY FORM

Student's Name: _____ DOB ____/____/____ Sex: Male
Last First Middle

Address: _____ City _____ Zip _____

Mother's Name (including maiden): _____ Phone: _____

Father's Name: _____ Phone: _____

Physician to be called: _____ Phone: _____

Has your child ever had any of the following? Please complete:

Asthma NO ☐ YES ☐ DATE _____

Chicken Pox NO ☐ YES ☐ DATE _____

Diabetes NO ☐ YES ☐ DATE _____ Specify _____

Ear Illness/Tubes NO ☐ YES ☐ DATE _____

Eye Problems NO ☐ YES ☐ DATE _____ Specify _____
Surgery/ Dysfunction/Glasses

Fifths Disease NO ☐ YES ☐ DATE _____

Frequent Sore Throat/ NO ☐ YES ☐ DATE(s) _____
Scarlet Fever / Rheumatic Fever

Head Injury/Concussion NO ☐ YES ☐ DATE (s) _____

Heart Disease NO ☐ YES ☐ DATE _____ Specify _____

Hepatitis NO ☐ YES ☐ DATE _____ Specify _____

Kidney Disease NO ☐ YES ☐ DATE _____

Measles/Mumps/Rubella NO ☐ YES ☐ DATE _____

Pneumonia NO ☐ YES ☐ DATE _____

Tuberculosis (TB) NO ☐ YES ☐ DATE _____

Whooping Cough NO ☐ YES ☐ DATE _____

Neurological Disorders NO ☐ YES ☐ DATE _____ Specify _____

(Asperger Syndrome, Autism, Cerebral Palsy, Epilepsy, Muscular Dystrophy, Traumatic Brain Injury)

Behavioral/Mental Health NO ☐ YES ☐ DATE _____ Specify _____

(ADD, ADHD, Anxiety, Bi-polar, Depression, OCD, ODD, PTSD, Schizophrenia)

(OVER)

Other (PLEASE SPECIFY) _____

PLEASE COMPLETE IN DETAIL THE FOLLOWING QUESTIONS RELATING TO YOUR CHILD

1) **Does your child have allergies? _____What kind? _____**

   Any allergies to food? _____What food(s)? _____

   Describe allergic reaction: _____

   Is it life threatening? _____ If your child is allergic to any foods, your physician must document it and the cafeteria & teacher will be notified.

2) Has your child had any operations/serious injuries? _____ If yes, what & when _____

   _____

   _____

3) Does your child have any urination/bowel problems that the school should be aware of? _____

   _____

4) Is there anything concerning the eyes, ears or general health of your child which the school should know in order to provide special care? _____

   _____

   _____

5) Does your child have any limitations on activities including recess on playground equipment and Physical Education class? _____

   _____

   IF SO, AN ANNUAL PHYSICAL ACTIVITY FORM MUST BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.

6) Is your child on any medication? _____ If yes, what medication/reason? _____

   _____

   _____

   Will any need to be administered during school hours? _ _____

- **ALL MEDICATIONS PRESCRIPTIONS AND OVER-THE-COUNTER, REQUIRE A PHYSICIAN'S WRITTEN ORDER (EXAMPLE: LOTIONS, CREAMS, OINTMENTS, COUGH MEDICINES, COUGH DROPS, ANALGESICS, ETC.) AN ADULT MUST BRING THE MEDICINE IN A PHARMACY/ORIGINAL LABELED CONTAINER TO THE NURSE'S OFFICE WHERE IT WILL BE KEPT IN A LOCKED CABINET AND ADMINISTERED ACCORDINGLY.**

MECHANICVILLE CITY SCHOOL DISTRICT
Mechanicville, New York

**** Not required - only complete to opt-out***

THIS FORM WILL BE VALID FOR THE DURATION OF THE STUDENT'S ENROLLMENT IN THE MECHANICVILLE CITY SCHOOL DISTRICT.

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or "BMI". The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. Recent changes to the New York State Education Law require that BMI and weight status group be included as part of the student's school health examination.

A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to New York State Department of Health information about our students' weight status groups. Only summary information is sent. **NO NAMES AND NO INFORMATION ABOUT INDIVIDUAL STUDENTS ARE SENT.** However, you may choose to have your child's information excluded from this survey report.

The information sent to the New York State Department of Health will help health officials develop programs that make it easier for children to be healthier.

If you DO NOT wish to have your child's weight status group information included as part of the Health Department's survey, please print and sign your name below and return this form to:

Mrs. Barb Sikamiotis, RN ~ Elementary School Nurse
OR
Mrs. Yvonne LaJeunesse, RN ~ Junior / Senior High Nurse

- -

Please **DO NOT** include my child's weight status information in any BMI school survey for their duration of enrollment in the Mechanicville City Schools.

_____ _____

Print Child's Name Date

_____ _____

Print Parent's Name Parent's Signature

CONSENT TO RELEASE FREE OR REDUCED PRICE ELIGIBILITY INFORMATION

School officials may release information that shows that my child/children are eligible for free or reduced price meals or free milk to the following programs. I understand that the information will only be provided to the program(s) checked.

(Check the box next to the program area(s) you wish to release information to)

☐ Federal health programs such as Medicaid or Children's Health Insurance Program (CHIP).

☐ State or federal programs such as the Youth Summer Work program or the Educational Talent Search Program.

☐ Local health and education programs and other local programs that provide benefits such as free textbooks or school supplies, free band instruments, or reduced fees for summer school or driver education.

☐ Community programs such as holiday baskets, summer arts and playground programs.

I understand that I will be releasing information that will show that my child/children are eligible for free and reduced price meals or free milk. I give consent to release my confidential information for the above named uses.

Child/Children

_____

_____

_____

I certify that I am the child's parent/guardian for whom the application was made.

Signature of Parent/Guardian: _____

Print Name: _____

Address: _____

Phone Number: _____

Date: _____