Dear Parent and Guardians:

Welcome to Carthage Central School District!

In order to ensure that the District has the most accurate and up to date information about your child, we have included the following information regarding the registration process.

Instructions to Register a Student in the Carthage Central School District:

1. Parent/Guardian must print and complete one (1) registration packet per student. Packets can be obtained from the school website at www.carthagecsd.org or any school building in the District.

It is important that numbers 2 and 3 below be completed BEFORE attending registration appointment!

2. Parent/Guardian must bring the following **Documentation of Age** for the child to the registration appointment:

✓ Documentation of Age should be produced as follows:

- (a) Where available, a certified transcript of a birth certificate or record of baptism, either foreign or domestic; or
- (b) If (a) is not available, either a foreign or domestic passport; or
- (c) If (a) or (b) are not available, any other documentary or recorded evidence in existance two or more years, including but not limited to the following:
  (1) official driver's license;
  (2) state or other government issued identification;
  (3) school photo identification with date of birth;
  (4) consulate identification card;
  (5) hospital or health records;
  (6) military dependent identification card;
  (7) documents issued by federal, state or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement);
  (8) court orders or other court-issued documents;
  (9) Native American tribal document; or
  (10) records from non-profit international aid agencies and voluntary agencies.

NOTE TO SCHOOLS/LEAS: **Please assist students and families filling out this form**. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the **student is not required to submit proof of residency** and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____ *Month Day Year* Grade: _____ *(preschool- 12)* ID #: _____ *(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

If **ANY box other than "In Permanent Housing" is checked,** then the student/family should be immediately referred to the MV Liaison. In such cases, proof of residency and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled. After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Rev. 11/15/16

3. Parent/Guardian must bring the following **Proof of Residency** to the registration appointment:

- ✓ Proof of residency: (one of the following is required)

HOMEOWNERS

Proof of Ownership, Original Tax Bill, Title, Mortgage Statement,
or Other Forms of Documentation below

OR

RENTERS

Original Lease (Parent/Guardian's name must appear on this lease)
or Other Forms of Documentation below

OR

LIVING WITH A HOMEOWNER OR RENTER OF THE DISTRICT

Resident of the District provided statement that parent/guardian and children reside in the District, along with proof of residency listed above.

OR

OTHER FORMS OF DOCUMENTATION

(a) Such other statements by third-party(s) establishing the parent(s)' or person(s) in parental relation's physical presence in the district;

(b) Documentation produced by the child, the child's parent(s) or person(s) in parental relation, including but not limited to the following:
(1) pay stub;
(2) income tax form;
(3) utility or other bills;
(4) membership documents (e.g., library cards) based upon residency;
(5) voter registration document(s);
(6) official driver's license, learner's permit or non-driver identification;
(7) state or other government issued identification;
(8) documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement); or
(9) evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers.

****Please note: The above Documentation of Age and Proof of Residency documentation is all that is required to complete the basic registration process. Your child may not be able to continue to attend school as a resident of the District without this information.****

If possible, the requested information below and on the following pages should also be provided during your initial appointment and registration of your child. Additional time and arrangments can be made at registration to produce the requested information and documentation and will not prevent your child from attending.

- ✓ Immunization records (up to date immunizations must be presented);
- ✓ Army Military ID (if applicable);
- ✓ Current physical no later than 12 months old signed by licensed physician, physician assistant, or nurse practitioner, who is authorized by law to practice in NY State; and
- ✓ Any other documentation to complete the following forms relevant to your child's education & enrollment.

CARTHAGE CENTRAL SCHOOL DISTRICT

36500 NY STATE ROUTE 26, CARTHAGE, NY 13619
PHONE: (315) 493-5000
www.carthagecsd.org

Student Registration Form

District Personnel ONLY – DO NOT write in this area **Enrollment Date:** _____/_____/_____

Student ID#:_____ **School:**_____

Grade: _____ **Teacher:** _____

Bus Route To: _____ **Bus Route From:** _____

Army Military ID ☐ **Army Civilian ID** ☐

Student Demographics *(Please print clearly)*

Student's Legal Name: _____
Last First Middle

Grade: _____ Gender: ☐M ☐F DOB: _____ Birth City/State: _____
Month /Day/Year

Resident Street Address: _____

_____ Apt./Bldg.: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Resident Mailing Address: _____

_____ Apt./Bldg.: _____

City: _____ State: _____ Zip: _____
(If different than street address)

Sibling(s) (in household)	DOB	Gender	Grade	School

Additional Services

Does your child have an Individualized Education Plan (IEP) or a 504 Accommodation Plan? ☐Yes ☐No

Has your child been diagnosed with ADD or ADHD? ☐ Yes ☐ No If yes, when? _____

Has your child ever been home schooled? ☐ Yes ☐ No If yes, when/how long? _____

What language(s) is spoken in the student's home or residence?
☐English ☐Other If other, specify _____

Parent/Guardian 1 Information

Parent/Guardian 1: _____ *Legal Guardian* ☐Yes ☐No *Receive School Mail* ☐Yes ☐No

Relationship to Student: _____

Lives in Household: ☐Yes ☐No If no, Resident Address: _____

Employer Name: _____ *Army Civilian* ☐Yes ☐No *Army Military* ☐Yes ☐No

If Military, Name of Brigade/Unit: _____ Rank _____

Parent/Guardian 1 Contact Information

Email:	
Second Email:	
Cell Phone:	
Work Phone:	
Home Phone:	

Parent/Guardian 2 Information

Parent/Guardian 2: _____ *Legal Guardian* ☐Yes ☐No *Receive School Mail* ☐Yes ☐No

Relationship to Student: _____

Lives in Household: ☐Yes ☐No If no, Resident Address: _____

Employer Name: _____ *Army Civilian* ☐Yes ☐No *Army Military* ☐Yes ☐No

If Military, Name of Brigade/Unit: _____ Rank _____

Parent/Guardian 2 Contact Information

Email:	
Second Email:	
Cell Phone:	
Work Phone:	
Home Phone:	

Additional Parent/Guardian Contact Information

CUSTODY INFORMATION

☐Two Parents in Home ☐Custody Transfer ☐Single Parent
☐Joint Custody ☐Separated ☐Emancipated
☐Sole Custody ☐Foster Placement (DSS-2999/3424 must be provided)

RESTRICTIONS OF CONTACT AND INFORMATION (PAPERWORK MUST BE PROVIDED)

☐Order of Protection
☐Papers Provided
Person Restricted_____
Exp. Date_____

☐Custody Papers Specify Restriction
☐Papers Provided
Person Restricted_____
Exp. Date_____

☐Other Documentation Provided
Specify_____

☐No Restrictions for Parents/Guardians

Additional LOCAL Emergency Contacts

For emergencies when parent/guardian cannot be reached and allows for pickup

*****In case of illness or injury, the school personnel are legally responsible for first aid only. It is the school policy to notify parents when home care or immediate medical care is indicated. Frequently, parents cannot be reached. Please list additional local emergency contacts in area provided below. Please DO NOT list a contact that is not local.*****

Emergency Contact 1: _____

Relationship to Student: _____

Lives in Household: ☐ Yes ☐ No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact 2: _____

Relationship to Student: _____

Lives in Household: ☐ Yes ☐ No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Transportation *If pick up/drop off is different than home address*

Transportation arrangements are made on the assumption that students are picked up and taken to the same address every day. If different arrangements need to be made, the school office MUST be contacted. IF student will be picked up or dropped off at a different address than home address, please specify below:

Pick up address: _____

_____

If pick up is childcare provider, please list name/number: _____

_____

Drop off address: _____

_____

If drop off is childcare provider, please list name/number: _____

_____

Middle/High School Based Health Center: I give consent for the School Based Health Center to have access to my child's records, including demographic and scheduling information, maintained by their school.
(Pertains to middle/high school students ONLY)

☐Yes ☐No

Ethnicity (Optional)

If not completed, determination will be made by school for State compliance

Is the child Hispanic, Latino, or of Spanish origin? (Hispanic, Latino or 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 ☐ 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 Alaskan Native:** *A person having origins in any of the original peoples of North and South America, and who maintains cultural identification through tribal affiliation or community recognition.*

☐ **Asian:** *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam.*

☐ **Black or African American:** *A person having origins in any of the Black racial groups of Africa.*

☐ **Native Hawaiian/Other Pacific Islander:** *A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

☐ **White:** *A person having origins in any of the original peoples of Europe, North Africa or the Middle East.*

Previous School Information

✓ Is your child presently under a suspension order from any other school district? ☐ Yes ☐ No

School last attended: _____

Grade: _____ School Year: _____ City/State: _____

✓ Has the student ever attended a Carthage School? ☐ Yes ☐ No

Carthage School: _____ Grade: _____ School Year: _____

Certification Statement

I hereby certify that the above information is true and accurate to the best of my knowledge.

Parent/Guardian Signature: _____

Date: _____

Carthage Central School District

Central Registration
36500 New York State Route 26
Carthage, New York 13619
Phone: (315)493-5000
www.carthagecsd.org

RECORDS TRANSFER REQUEST FORM

Must be filled out <u>even</u> if previous school records are hand carried.

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

Parent/Legal Guardian _____ hereby authorizes

_____
Previous School

_____
Address

_____
City *State* *Zip*

Phone: _____ *Fax:* _____

To release and/or exchange a copy of all academic and confidential information pertaining to the above student to the following (√) school: (Please include: Birth Certificate, Social Security Card, Health Records, Academic Records including Standardized Testing, Last Report Card and Sign-Out Grades, Confidential/Psychological/Special Education Records, IEP, 504 Plan, Custody or Guardianship Papers.)

☐ PRINCIPAL
Black River Elementary School
160 Leray Street
Black River, NY 13612
Fax: (315) 773-3747 Ph: (315) 773-5911
Email: pclark@carthagecsd.org
kbell@carthagecsd.org

☐ GUIDANCE
Carthage Middle School
21986 Cole Road
Carthage, NY 13619
Fax: (315) 493-6031 Ph: (315) 493-5020
Email: dhayden@carthagecsd.org

☐ PRINCIPAL
Carthage Elementary School
900 Beaver Lane
Carthage, NY 13619
Fax: (315) 493-6028 Ph: (315) 493-1570
Email: lnevills@carthagecsd.org

☐ GUIDANCE
Carthage High School
36500 State Route 26
Carthage, NY 13619
Fax: (315) 493-1401 Ph: (315) 493-5035
Email: klyndaker@carthagecsd.org

☐ PRINCIPAL
West Carthage Elementary School
21568 Cole Road
Carthage, NY 13619
Fax: (315) 493-6536 Ph: (315) 493-2400
Email: mlynn@carthagecsd.org

☐ SPECIAL EDUCATION OFFICE
Carthage Central School District
25059 Woolworth Street
Carthage, NY 13619
Fax: (315) 493-1771 Ph: (315) 493-5067
Email: icarey@carthagecsd.org

_____ _____
Signature of Parent/Guardian **Date**

Carthage Central School District

Central Registration
36500 New York State Route 26
Carthage, New York 13619
315-493-5000 Fax: 315-493-1691
www.carthagecsd.org

Date: _____

Dear Parents/Guardians,

Health appraisals are required for all students newly entering the district, students in Prekindergarten **or** Kindergarten, Grades 1, 3, 5, 7, 9 and 11. Health appraisals are also required to participate in interscholastic sports.

The American Academy of Pediatrics recommends that school age children receive a complete health appraisal by their primary medical provider each year. Regular visits with a primary care provider promote continuity of care and ability to better track growth and development.

Please submit the required health certificate/appraisal form from your private provider **no more than thirty (30) days** after the start of the school year (Education Law §903, 8 NYCRR §136.3 [c][1]). If your child has an appointment for an exam that is after the first thirty (30) days of school, NYS requires you to notify the School Nurse with the appointment date and time.

In the event you are unable to have your private physician complete the health appraisal one can be done by the School Medical Director or designee. A health appraisal conducted by the School Physician is a basic health screening and **does not** include checks for hernias or inspection of genitals. If you would like a hernia/genital screen on your child, parental permission/request must be completed.

Check one (1):

☐ I have attached a copy of the completed health certificate form signed by a **New York State** licensed provider, or military sponsored healthcare provider as required by New York State.

☐ My student has an appointment on Date/Time _____ with _____.
I will send a copy of the completed health certificate form signed by a **New York State** licensed provider, or military sponsored healthcare provider as required by New York State to the school nurse immediately following the appointment.

☐ I enrolled my child in the School Based Health Center (Middle & High only) and their staff will complete the required health appraisal.

☐ I am requesting that my child has their health appraisal completed by the School Physician. I will complete and return the Health History Update for the physician to review.

☐ I want my child to have a genital/hernia exam.

Student Name: _____ Grade: _____ DOB: _____

Signature of Parent/Guardian: _____ Date: _____

Office Staff - Please return to the School Nurse

Carthage Central School District

Central Registration
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Carthage, New York 13619
315-493-5000 Fax: 315-493-1691
www.carthagecsd.org

Food Allergy Health History Form

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

Parent/Guardian Name: _____ **Phone:** _____

Primary Healthcare Provider: _____ **Phone:** _____

Allergist: _____ **Phone:** _____

1. Does your child have a diagnosis of an allergy from a healthcare provider?

☐ **No** (If no, please skip to page 13) ☐ **Yes** (please attach documentation and have healthcare provider complete page 12)

Documentation must be provided to the school if requesting food substitutes.

2. History and Current Status

Please be specific as possible, label whether they can have cooked or not, etc.

Allergy to: (circle)	List type of reaction: (i.e. itching, hives, throat swelling)
Peanuts	
Eggs	
Tree Nuts (walnuts, pecans, etc.)	
Milk	
Soy	
Fish/Shellfish	
Other:	

Additional Comments: _____

_____

_____

3. How is your child's reaction triggered? ☐ Ingested ☐ Touch ☐ Inhaled ☐ Other: _____

4. Does your child have prescribed medication for this allergy?

☐ No ☐ **Yes**, ***please have your healthcare provider complete the Allergy Emergency Action Plan*** ***(Page 12)***

5. Have you ever had to use an EpiPen for this allergy? ☐ No ☐ **Yes**, how many times? _____

6. Does your child need to sit at a "safe" table for lunch? ☐ No ☐ Yes

7. Is your child able to monitor and prevent his/her own exposures? ☐ No ☐ Yes

8. Does your child know what foods to avoid? ☐ No ☐ Yes

9. Is your child able to tell peers and adults about their allergy and refuse a problem food? ☐ No ☐ Yes

_____

Parent's Signature **Date**

Office Staff - Please return to the School Nurse

Carthage Central School District

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315-493-5000 Fax: 315-493-1691
www.carthagecsd.org

ALLERGY EMERGENCY ACTION PLAN

(Completed by Healthcare Provider ONLY if child has been diagnosed with a health allergy)

Name of Student: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

To be completed by Allergy Specialist or Primary Care Provider:

Allergy to: _____

Asthma: ☐Yes *(high risk for severe reaction)* ☐No

Additional health problems besides anaphylaxis: _____

_____

Concurrent medications: _____

Symptoms of Anaphylaxis		Give Checked Medication	
MOUTH	itching, swelling of lips and/or tongue	☐ Epinephrine	☐ Antihistamine
THROAT*	itching, tightness/closure, hoarseness	☐ Epinephrine	☐ Antihistamine
SKIN	itching, hives, redness, swelling	☐ Epinephrine	☐ Antihistamine
GUT	vomiting, diarrhea, cramps	☐ Epinephrine	☐ Antihistamine
LUNG*	shortness of breath, cough, wheeze	☐ Epinephrine	☐ Antihistamine
HEART*	weak pulse, dizziness, passing out	☐ Epinephrine	☐ Antihistamine

Only a few symptoms may be present. Severity of symptoms can change quickly.
**Some symptoms can be life-threatening. ACT FAST!*

Emergency Action Steps - DO NOT HESITATE TO GIVE EPINEPHRINE!

1.Inject epinephrine in thigh using (check one):
☐ EpiPen Jr (0.15 mg) ☐ EpiPen (0.3 mg)

Epinephrine Auto-injector- authorized generic
☐ (0.15 mg) ☐ (0.3 mg)

2. Call 911 if Epinephrine is administered!

Permission to self-carry

(check one) ☐ YES ☐ NO

By checking YES, you attest that the student has demonstrated proper knowledge of using this medication.

3. Antihistamine: Benadryl or Diphenhydramine HCL, Dosage _____ every _____ hours PRN

4. Albuterol HFA 2 puffs INH every _____ hours PRN coughing, wheezing, shortness of breath

5. Other: _____

_____
Qualified Medical Practitioner's Signature Date Phone Number

_____
Parent's Signature Date

Please return to the School Nurse

Carthage Central School District

Central Registration
36500 New York State Route 26
Carthage, New York 13619
Phone: (315)493-5000
www.carthagecsd.org

MEDICAL RELEASE AUTHORIZATION FORM

MEDICAL AUTHORIZATION RELEASE

STUDENT NAME: _____

HOME ADDRESS: _____

_____

_____

HOME TELEPHONE NUMBER: _____

AUTHORIZATION AND RELEASE

In case of emergency, officials of the Carthage Central School District are hereby authorized to arrange for medical or dental treatment for the above named student. This authorization includes transportation to an emergency room, first aid, treatment and other action deemed necessary by the official, medical staff, or dentist. I understand that the school district cannot assume responsibility for the payment of medical fees or expenses incurred.

_____ _____

Signature of Parent or Legal Guardian **Date**

Name of Family Physician: _____

Telephone Number: _____

Insurance Company: _____

Policy Number: _____

Employer: _____

Allergies of Special Circumstances: _____

**Currently on Medication? ☐Yes ☐No

If yes, please list (see statement below): _____

(If yes AND medication is taken during school hours, please have a medication permission form (obtained @ school or on District website) completed by physician and returned to school nurse)

Office Staff - Please return to the School Nurse

Carthage Central School District
36500 New York State Route 26
Carthage, New York 13619
315-493-5000 Fax: 315-493-1691
www.carthagecsd.org

Annual Health History Update
Please be sure to update us throughout the year with changes!

Student Name:	DOB:	Age:	Grade:
Parent/Guardian:	Home Phone:		Cell:
Family Physician:	Phone:		

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
List Allergies/Reactions:			
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐peak flow monitoring ☐special diet

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD	☐ GI Conditions (ulcer, reflux, IBS)	☐ Scoliosis
☐ Asthma/trouble breathing	☐ Headaches/migraines	☐ Single Organ (☐kidney, ☐testicle)
☐ Autism/Asperger	☐ Heart Conditions	☐ Skin Condition_____
☐ Dental Injuries	☐ High Blood Pressure	☐ Speech Condition_____
☐ Diabetes	☐ Mental Health Condition (circle)	☐ Urinary Condition_____
☐ Ear Conditions	(anxiety, depression, OCD, ODD, etc.)	☐ Other: _____

Please list ALL medications taken at home and needed at school. A school order is needed for any medications to be taken at school or during any school sponsored activity including sports and field trips.

Medication Name i.e. (Tylenol, Albuterol)	Dose (mg, units)	Route (Oral)	Frequency (Times taken)	Purpose (Asthma, etc.)	Required during school hours:	School Order provided to Nurse:
					☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No
					☐Yes ☐No	☐Yes ☐No

Please list any additional concerns on back of sheet and update the school nurse with changes throughout the year!

Parent/Guardian Signature: _____ Date: _____

Reviewed by (Name/Title): _____ *Date:* _____

Office Staff - Please return to the School Nurse