CORTLAND ENLARGED CITY SCHOOL DISTRICT

Dear Parent/Guardian:

Welcome to the Cortland Enlarged City School District, CECSD.

To begin the enrollment process, please complete the enclosed registration forms fully. Should you need assistance, please contact the registrar at 607 758-4106.

You will need to bring the completed forms and required documents in hand to the district office, One Valley View Drive, Cortland, NY

Registration forms can NOT be processed without required documents.

The following items are **REQUIRED** for your child to be registered:

- **Completed registration forms**
- **Proof of residency**
- **Proof of age**
- **Immunization records (if applicable)**
- **Custody agreement(s) and/or court order(s) (if applicable)**

Please refer to the "Acceptable Proof" lists below.

Acceptable Proof of Residency:

- Copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement;
- Statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the District, which may be either sworn or unsworn; or
- Other statement by a third party establishing the parent(s) or person(s) in parental relation's physical presence in the district.
- If these are not available, you may also show the following items with parent(s) or person(s) in parental relation name(s) and address listed:
    - Pay stub;
    - Income tax form;
    - Utility or other bills;
    - Membership documents (e.g., library cards) based upon residency;
    - Voter registration document(s);
    - Official driver's license, learner's permit, or non-driver identification;
    - state or other government issued identification;
    - Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement); or
    - Evidence of custody of the child, including but not limited to judicial custody or guardianship papers.

Acceptable Proof of Age:

- Birth certificate;
- Record of baptism; or
- Passport.
- If these are not available, you may also show:
    - Official driver's license;
    - State or other government issued identification; or 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 (e.g., local social service agency, federal Office of Refugee Resettlement);
    - Court orders or other court-issued documents;
    - Native American tribal document; or
    - Records from non-profit international aid agencies and voluntary agencies.

Acceptable Proof of Custody or Guardianship (if applicable):

- Current final or temporary court order;
    - needs to specify custody and placement
    - needs to be signed by Judge
- An affidavit (written statement signed under oath) saying that you have "total and permanent custody and control" over the child;
- Other proof such as documentation that the child has been placed with a sponsor by a federal agency.

Please include any "stay away" and/or "orders of protection"

Immunization and Health Records are **REQUIRED** if the student is not transferring to CECSD from another New York State public school district.

All required documents need to be CURRENT.

Please feel free to contact the registrar should you have any questions or need assistance throughout the enrollment process.

Kendra Chambers
Central Registrar
Pupil and Personnel Information Coordinator

1 Valley View Drive
Cortland, NY 13045

607 758-4106 (Ph.)
607 758-4109 (Fx.)
kchambers@cortlandschools.org

CORTLAND ENLARGED CITY SCHOOL DISTRICT

1 Valley View Drive, Cortland, NY 13045
Phone: 607-758-4106 Registration Office Fax: 607-758-4109
www.cortlandschools.org

Student Information

Student's Legal Name: _____ _____ _____
First Last Middle

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: _____
Month Day Year

Birthplace: _____
City State/Province/Region County Country

Student Ethnicity and Race Identification:

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status. Please check all appropriate selections.

1. Ethnicity: Hispanic, Latino or of Spanish origin — Yes ☐ No ☐

2. Race:

American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White
☐	☐	☐	☐	☐

Dominant language spoken in the home: English ☐ Other ☐ _____

Previous school(s) attended: 1. _____
Name of School City, State Phone

2. _____
Name of School City, State Phone

Special Services:
Individual Education Plan (IEP) ☐ 504 Accommodation Plan ☐ None ☐

Grade Level: _____

Home Address: _____
Number and Street

_____
City State Zip

Mailing Address: _____
(If different than home address) Number and Street or PO Box #

_____
City State Zip

Date moved into present address: _____
Month Day Year

Is this address a temporary living arrangement? Yes ☐ No ☐

If yes, is this temporary arrangement due to loss of housing or economic hardship? Yes ☐ No ☐

_____ _____
Print Name Signature

Parent/Guardian Information

Student Name:_____ Date of Birth:_____

Student lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Parents

Custody agreement(s), court order(s) other legal documents:

☐ Custody agreement ☐ Order of Protection ☐ Adoption papers ☐ Foster papers ☐ Other ☐ None

Primary Parent/Guardian:

Name: _____
First Last MI

Relationship to student:_____

Address:_____ Home phone:_____

_____ Cell phone:_____

Email address:_____

Employer:_____ Work Phone:_____

Position:_____

Additional Parent/Guardian:

Name: _____
First Last MI

Relationship to student:_____

Address:_____ Home phone:_____

_____ Cell phone:_____

Email address:_____

Employer:_____ Work Phone:_____

Position:_____

Sibling Information

(Living in the home, school age and younger)

Name (first, last)	Gender	Date of Birth (mm/dd/yyyy)	Grade	Relationship to Student
_____	☐ Male ☐ Female	_____	_____	_____
_____	☐ Male ☐ Female	_____	_____	_____
_____	☐ Male ☐ Female	_____	_____	_____
_____	☐ Male ☐ Female	_____	_____	_____
_____	☐ Male ☐ Female	_____	_____	_____
_____	☐ Male ☐ Female	_____	_____	_____

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:
			❑ Male ❑ Female
Month	*Day*	*Year*	
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? _____

_____ Month: Day: Year:

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:

Emergency Contact Information

Please list the information of individuals who may be contacted in the event of an emergency (should a parent/guardian be unreachable). Accurate and up-to-date information is essential. Please include day care information first, if applicable. Note that only persons listed as authorized to pick up students will be allowed to do so.

Student Name:_____ Date of Birth:_____

Contact 1: _____
Last First M.I.

Authorized for pick up?
☐ Yes ☐ No

Relationship to student _____

_____
Number Street City State Zip

Home phone _____ Work phone_____Cell phone _____

Contact 2: _____
Last First M.I.

Authorized for pick up?
☐ Yes ☐ No

Relationship to student _____

_____
Number Street City State Zip

Home phone _____ Work phone_____Cell phone _____

Contact 3: _____
Last First M.I.

Authorized for pick up?
☐ Yes ☐ No

Relationship to student _____

_____
Number Street City State Zip

Home phone _____ Work phone_____Cell phone _____

Contact 4: _____
Last First M.I.

Authorized for pick up?
☐ Yes ☐ No

Relationship to student _____

_____
Number Street City State Zip

Home phone _____ Work phone_____ Cell phone _____

Parent/Guardian signature_____Date _____

Student Transportation Form

Student's Legal Name_____ Male ☐ Female ☐ Grade Entering_____
Last First Middle

Date of Birth_____ Primary language spoken at home_____
Month Day Year

Home Address_____
Exact street location (911 address)

Primary Parent/Guardian: _____ Phone: _____
First Last

Additional Parent/Guardian: _____ Phone: _____
First Last

Mailing Address_____
(If different and/or a P.O. box)

Will student be picked up at a different location other than home address?
If so, please specify:

☐ Daycare provider (Includes grandparents and parent(s) outside of primary address)

☐ Shared Custody

Both require Before and After School Childcare Request Form to be filled out and turned in to Transportation Department.

Emergency Contacts

Contact 1: _____ Home phone _____
First Last

_____
Exact street location (911 address)

Contact 2: _____ Home phone _____
First Last

_____
Exact street location (911 address)

"I authorize the Cortland Enlarged City School District to drop off my Elementary Student, or my Student with a Disability from the bus without an adult present to receive the child. This authorization will remain in effect until the next school year, unless I inform you otherwise in writing."

Parent/Guardian signature_____ Date _____

Transportation Department Use Only

Route _____

Driver _____

Copy to School _____

Student Health Information Form

CORTLAND ENLARGED CITY SCHOOL DISTRICT
1 Valley View Drive, Cortland, NY 13045
Phone: 607-758-4100 District Office Fax: 607-758-4109
www.cortlandschools.org

New York State mandates that health examinations are required for all students entering grades **PreK or K, 1, 3, 5, 7, 9, and 11** and for all students; new to the district, through special education, participating in interscholastic sports (require yearly physical), needing working papers, or who are deemed necessary by school authorities to determine a child's education program. In compliance with this law, School Health Care Providers will be available periodically throughout the year to perform student physicals. However, if your child has had a physical exam with their health care provider (dated not more than twelve months before the beginning of the school year), please see that we receive a copy of the examination and it will not be necessary for your child to have a physical performed in school. For students entering the district after the beginning of the school year, the exam must be dated no more than one year before the student's first day at CECSD. **Your family doctor can best evaluate your child's health. He/She can also provide any needed treatment or referrals. The health form, which your doctor completes, becomes part of your child's student health record.**

Examinations can be obtained in school. If you prefer the school exam, please indicate below. Within 60 days from the date of school entry, if we do not receive the completed health form from your doctor or notice of an upcoming appointment, your child will be added to the group of school exams.

Cortland Enlarged City School District is randomly selected by the state to provide Body Mass Index (BMI) data within the school district. The information is taken from the K, 2, 4, 7, & 10 physicals. Each student's health appraisal is required to include BMI and determination of weight status. If you do not want your child's data to be included in the survey please contact your school nurse. (Number data only – no names are used.)

New York State also requires a Dental Health Certificate, to be completed and signed by a Dentist, on all new entrants and students in grades K, 1, 3, 5, 7, 9 and 11.

This section must be completed by parent/guardian

Student's Name _____ Date of Birth _____

☐ Male ☐ Female Last School Attended _____

Student's Health Care Provider(s) _____ Phone(s) _____

Student's Dentist _____ Phone _____

Name of Parent/Guardian completing this form (please print) _____

☐ I will provide Cortland Enlarged City School District with a copy of my child's latest well-child physical examination from their personal healthcare provider within 30 days of my child's entry.

☐ I would like my child to have a school physical. I expect to be informed of any possible problems.

****When completing the following, please attach another sheet of paper if necessary:**

History of Illness: Please indicate the year in which your child had any of the following diseases or conditions:

Mumps	Whooping Cough	Skin Condition	Concussion
Measles	Rheumatic Fever	Ear Condition	Serious Injuries
Chicken Pox	Significant Illness		

Please check below any conditions affecting your child, which may affect his/her welfare in school. For example: asthma, diabetes, severe allergies, vision or hearing defect, etc.

☐ Drug allergy	☐ ADD/ADHD	☐ Heart condition	☐ Seizure disorders
☐ Food allergy	☐ Diabetes	☐ Pneumonia	☐ Recent injuries
☐ Insect/bee allergy	☐ Asthma	☐ Kidney disease	☐ Hearing problems
☐ Environmental allergy	☐ Arthritis	☐ Vision problems	☐ Recent surgeries

Please explain all items checked above including allergy reactions:

_____

_____

_____

_____

(Continued)

Please add any conditions not listed:

_____
_____
_____
_____

Does this student take any medications/vitamins/over the counter medications regularly at home? ☐ Yes ☐ No
If yes, please list medication(s) including dosage and frequency:

_____
_____
_____
_____

Will this student require medication administration at school? ☐ **Yes*** ☐ No
***If yes, please provide to your school's Health Office: (1) a physician signed medical order, (2) permission to administer the medication in school- signed by a parent/guardian, and (3) the medication itself- in its original container- clearly marked with the student's name.**
If yes, please list medications with dosage and frequency:

_____
_____
_____
_____

Does your child wear glasses, hearing aids or other devices? ☐ Yes ☐ No _____

Is your child toilet trained? ☐ Yes ☐ No If no, please explain: _____

Has your child ever been stung by a bee? ☐ Yes ☐ No If yes, describe reaction:_____

Any family history of bee sting allergy? ☐ Yes ☐ No If yes, describe reaction:_____

Parent/Guardian Signature_____Date _____

For RN use: Physical provided ☐ Yes ☐ No

Immunizations: ☐ UTD ☐ Required ☐ Exempt

Medicaid Consent Notification

Cortland Enlarged City School District
Committee on Special Education
1 Valley View Drive
Cortland, NY 13045

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

This form has been adapted from the U.S. Department of Education's model Notification Form[1].

INTRODUCTION

You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district/county to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district (or, for preschool students, the county) to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district or county can ask you to provide consent to check with the New York State Department of Health whether your child has public benefits or insurance (e.g., Medicaid coverage and/or a Client Identification Number (CIN)), and to access these benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. Whether or not you provide consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT

34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)

Before your school district (or for preschool students, your county) can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time.

This consent requirement has two parts.

1 For the full Suggested Model for Written Notification of Parental Rights regarding Use of Public Benefits or Insurance developed by the U.S. Department of Education, see: http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/accmodelwrittennotification-6-11-13.pdf

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing (sharing) personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the school district will (1) identify the records (or information) about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

2. Consent to check with the New York State Department of Health whether your child has a CIN/public benefits or insurance (Medicaid) coverage, and bill your child's public benefits or insurance (Medicaid) program: Your consent must include a statement specifying that you understand and agree that your school district or county, for preschool, may use you or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS

34 CFR §300.154(d)(2)(i)-(iii) and 8 NYCRR §200.5(b)(8)(ii)(b)-(d)

The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for or enroll in a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.

3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:
    a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;
    b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;
    c. increase your premium or lead to the cancellation of your public benefits or insurance; or
    d. cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district or county, for the provision of preschool special education, to use your or your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see: http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parentalconsent.htm

Please fill in your and your child's names & sign the bottom of the form even if you DO NOT have MEDICAID. This form will stay in your child's file, and will only be used if/when your child receives special education services.

Medicaid Consent Form

Cortland Enlarged City School District
Committee on Special Education
1 Valley View Drive
Cortland, NY 13045
(607)758-4100

Student Name:_ _____

Date of Birth: _____

Parent Name _____ Client Identification Number (CIN): _____

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____as the parent/guardian of _____,
(print name of parent/guardian) *(please print name of child)*

have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Medicaid CIN # ☐☐ ☐☐☐☐☐☐ Or Initial here:_____ My Child is NOT Eligible for Medicaid.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____