CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION INFORMATION

Please indicate the school year for which you are registering your child:

☐ Current(2024-25) ☐ Upcoming(2025-26)

Dear Parent/Guardian,

Welcome to the Cortland Enlarged City School District.To begin the enrollment process, please complete all registration forms fully. Upon completion of these forms, you will need to bring these and all required documents to the registrar, located in the district office at 1 Valley View Drive, Cortland or submit electronically to registrar@cortlandschools.org.

Registrations CANNOT be processed in the absence of all required documents.

The following items must be submitted along with the registration forms in order to be processed:

- ☐ Proof of Residency
- ☐ Proof of Age
- ☐ Immunization Records
- ☐ Custody Agreements and/or Court Orders including any Stay Away Orders and/or Orders of Protection

For your reference, please review the following list of acceptable documents to fulfill registration requirements:

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 or guardian leases or with whom they share property within the district, which may be either sworn or unsworn;
- Other statement by a third party establishing the parent or guardian's physical presence in the district
- If none of the above items are available, you may also garnish any one of the following so long as the document is **valid** and the parent or guardian's name and address are listed:
  - Pay stubs;
  - Income tax form;
  - Utility or other bills;
  - Membership documents (e.g., library cards) based upon residency;
  - Voter registration documents;
  - **Valid** state or other government issued identification;
  - Documents issued by federal, state, or local government 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, current court order which specifies custody and placement, an affidavit, signed under oath, indicating "total and permanent custody and control" of the child, or documentation that the child has been placed by a federal agency.

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION INFORMATION

Acceptable Proof of Age:

- ORIGINAL birth certificate;
- Record of baptism;
- **Valid** passport;
- If none of the above items are available, you may also garnish any one of the following so long as the document is **valid** and displays the child's date of birth:
  - Official driver's license or learner's permit;
  - State or other government issued identification;
  - School photo identification card;
  - Consulate identification card;
  - Hospital or health records;
  - Documents issued by federal, state, or local government agencies (e.g., local Social Service Agency, Federal Office of Refugee Resettlement);
  - Court orders or other court-issued documents;
  - Native American tribal documents;

Please note that **expired** documents will be deemed **invalid** and are not acceptable documents of proof. All submitted documents must be **current**.

If you require assistance or have questions or concerns at any point in the registration process, please forward all inquiries to the central registrar:

Jade Zupancic
Central Registrar - Student Registration
Executive Secretary of Pupil and Personnel Services
Cortland Enlarged City School District
1 Valley View Drive
Cortland, NY 13045
e. registrar@cortlandschools.org
p. (607) 758-4106
f. (607) 758-4109

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

STUDENT INFORMATION

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

Preferred Name: _____ Gender: _____ Grade: ____ Date of Birth: _____
(*mm/dd/yyyy*)

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 on the basis of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status. Check all that apply.

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

2. Race: ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White

Most Recent School Attended: _____ _____ _____
Name of School City, State Phone

Prior School (if attended most recent for fewer than 6 months) _____ _____ _____
Name of School City, State Phone

Special Services: At their most recent school, or through Early Intervention, was an IEP or 504 Accommodation Plan put in place to meet the specific needs of your child? Yes ☐ No ☐

If 'Yes': ☐ IEP **OR** ☐ 504 Accommodation Plan

Is your mailing address the same as your physical address? ☐ Yes ☐ No

If 'No': _____
Mailing Street City State Zip

Home Address: _____
Street City State Zip

Date moved into current address: _____ ☐ Permanent Housing ☐ Temporary Housing
(*mm/dd/yyyy*)

If temporary, is this arrangement due to economic hardship? ☐ Yes ☐ No

_____ _____
Print Name Signature

FOR OFFICE USE ONLY

MKV ☐ IEP/504 ☐ ELL ☐ Legal ☐ Mailing ☐ Current SY ☐ or 20___/___ ☐

Date Submitted: _____ PoA ☐ PoR ☐ Imm. ☐

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

PARENT/GUARDIAN INFORMATION

Student Name: _____ Date of Birth: _____

Are there any legal documents regarding the student? ☐ Yes ☐ No

If 'Yes', check all that apply: ☐ Custody Agreement ☐ Order of Protection ☐ Adoption Papers ☐ Foster Papers

Primary Parent/Guardian**:** _____ _____ _____
First Last M.I.

Relationship to Student: _____

Address: _____
Street City State Zip

Email Address: _____

Phone Numbers: _____ _____ _____ _____
Cell Home Work Ext.

Additional Parent/Guardian**:** _____ _____ _____
First Last M.I.

Relationship to Student: _____

Address: _____
Street City State Zip

Email Address: _____

Phone Numbers: _____ _____ _____ _____
Cell Home Work Ext.

Sibling Information

(School Age and Younger)

Child's Name (First and Last)	Gender	Date of Birth (mm/dd/yyyy)	Relationship to Student

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

EMERGENCY CONTACT INFORMATION

This information will be used to verify an individual is authorized by the primary guardian to pick up the student. Any and all individuals entered here may be contacted in the event of an emergency should the parent(s)/guardian(s) be unreachable. Emergency contacts will be called in the same order as they are entered on this form.

Student Name: _____ Date of Birth: _____

Contact 1: _____ _____ _____ Authorized for pickup?
First M.I. Last ☐ Yes ☐ No

Relationship to Student: _____

Address: _____
Street City State Zip

Phone Numbers: _____ _____ _____ _____
Cell Home Work Ext.

Contact 2: _____ _____ _____ Authorized for pickup?
First M.I. Last ☐ Yes ☐ No

Relationship to Student: _____

Address: _____
Street City State Zip

Phone Numbers: _____ _____ _____ _____
Cell Home Work Ext.

Contact 3: _____ _____ _____ Authorized for pickup?
First M.I. Last ☐ Yes ☐ No

Relationship to Student: _____

Address: _____
Street City State Zip

Phone Numbers: _____ _____ _____ _____
Cell Home Work Ext.

Contact 4: _____ _____ _____ Authorized for pickup?
First M.I. Last ☐ Yes ☐ No

Relationship to Student: _____

Address: _____
Street City State Zip

Phone Numbers: _____ _____ _____ _____
Cell Home Work Ext.

Parent/Guardian Signature: _____ Date: _____

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

HOUSING QUESTIONNAIRE

District (LEA): _____

Name of School: _____

Student Name: _____ _____ _____
Last First Middle

Gender: _____ Date of Birth: _____ Grade: _____ Phone: _____
(*mm/dd/yy*)

Address: _____
Street City State Zip

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
- ☐ Other temporary living situation: _____
- ☐ In permanent housing

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

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

_____
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.

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*

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?	❑ Parent 1 _____ *specify*	❑ Parent 2 _____ *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: ☐ **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:

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

TRANSPORTATION REQUEST FORM

If your student currently rides a bus, and plans to ride this coming year, NO form is needed.
If your student is a Kindergartner and needs transportation to/from home, fill out *Sections 1 and 3.
If your student needs to be transported to/from anywhere other than your home address,
fill out *Sections 1, 2, and 3.
(Please allow **48 hours** for processing)

Please complete a separate form for each student

***Section 1 Student Information/Home Address**

Child's Name: _____ Grade:_____

Home Address: _____

Exact street location (911 Address)

Mother's Name:_____ Cell:_____ Work:_____

Father's name:_____ Cell:_____ Work:_____

***Section 2 Alternative Site Information**

Alternative Location Provider's Name: _____ Phone :_____

Address: _____

Exact street location (911 Address)

***Section 3 Location and Days Transportation is Needed**

Enter either HOME or ALTERNATIVE SITE on the line below to indicate the location for pickup and dropoff.

Indicate which days your child will need transportation by placing a check mark in the box BELOW the day.

TO SCHOOL from _____

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

☐ ☐ ☐ ☐ ☐

FROM SCHOOL to _____

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

☐ ☐ ☐ ☐ ☐

Parent/Guardian Signature: _____ Date: _____

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

STUDENT HEALTH INFORMATION: Part I

NOTICE: New York State mandates that health examinations are required for all new students and current students entering grades **Pre-K, Kindergarten, 1, 3, 5, 7, 9,** and **11** and also for students who participate in interscholastic sports, seek working papers, or are deemed necessary by school authorities or the district Committees on Special Education or Preschool Special Education (CSE/CPSE) to determine the child's education program. Health examinations are offered by School Healthcare Providers periodically throughout the year. If you choose to have your family doctor conduct such examinations, please be sure to provide the district with a copy of the examination or notification of an upcoming appointment. Failure to do so within 60 days from the date of school entry will result in your child being scheduled for an exam with the School Healthcare Providers. New York State also requires a Dental Health Certificate, to be completed and signed by a dentist, for all new students and students in grades Kindergarten, 1, 3, 5, 7, 9, and 11.

Cortland Enlarged City School District has been randomly selected by the state to report Body Mass Index (BMI) data within the district. The information is taken from the following grades: Kindergarten, 2, 4, 7, and 10 physicals. Each student's health appraisal is required to include BMI and determination of weight status. For this reporting purpose, number data only is sent to the state; no names are included. If you do not want your child's data to be included in the survey, please contact your school nurse.

This section must be completed by the student's parent/guardian.

Student Name: _____ _____ Date of Birth: _____
Last First

Gender: _____ Last School Attended: _____

Student's Healthcare Provider: _____ Phone: _____

Student's Dentist: _____ Phone: _____

Health Examination Preference:

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

☐ I would like my child to be scheduled for a physical examination with a School Healthcare Provider. I expect to be informed of any possible problems

History of Illness:

Please enter the year in which your child had the following diseases or conditions, if any, on the line to the right of the illness.

Mumps _____
Measles _____
Chicken Pox _____
Whooping Cough _____

Rheumatic Fever _____
Skin Condition _____
Ear Condition _____
Concussion _____

Other Serious Injury or Illness:
_____
_____

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

STUDENT HEALTH INFORMATION: Part II

Please indicate which, if any, of the following conditions presently affect or have at one point affected your child:

- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ Bee/Insect Allergy
- ☐ Environmental Allergy
- ☐ ADD/ADHD
- ☐ Diabetes
- ☐ Asthma
- ☐ Arthritis
- ☐ Heart Condition
- ☐ Pneumonia
- ☐ Kidney Disease
- ☐ Vision Problems
- ☐ Seizure Disorders
- ☐ Hearing Problems

Please explain all check items including allergies:

_____

_____

_____

Has your child had any recent serious injuries or surgeries? ☐ Yes ☐ No
If 'Yes,' please describe and include dates: _____

_____

_____

Does your child have a condition not listed above? ☐ Yes ☐ No
If 'Yes,' please describe: _____

_____

_____

Does your child take any prescribed medications, vitamins or over-the-counter medications regularly? ☐ Yes ☐ No
If 'Yes,' please list below. Include dosage and frequency: _____

_____

_____

Will your child require medication administration at school? ☐ Yes ☐ No
If 'Yes,' please list below. Include dosage and frequency: _____

_____

_____

***In order for medication to be administered in school you MUST provide your school's Health Office with: (1) a physician signed medical order, (2) written and signed consent from parent/guardian for the administration of such medication, and (3) the medication itself which MUST remain in the original container and clearly display the student's full legal name.**

Does your child wear glasses, hearing aids or other devices? ☐ Yes ☐ No If 'Yes:' _____
Is your child toilet trained? ☐ Yes ☐ No Has your child ever been stung by a bee? ☐ Yes ☐ No
Is there a family history of bee sting allergy? ☐ Yes ☐ No If 'Yes' to either, explain: _____

_____

Parent/Guardian Signature: _____ Date: _____

For RN use: Physical Provided: ☐ Yes ☐ No

Immunizations: ☐ UTD ☐ Required ☐ Exempt

Cortland Enlarged City School District

School Health Services Consent Form

Dear Parent/Guardian:

School Health Services in partnership with Guthrie Cortland Medical Center will continue to be offered throughout the 2024-25 school year. We know that students' health and success in school are absolutely connected. We hope that by bringing health services directly to students during the school day, we can proactively meet their health needs and support overall health, wellness and school attendance.

If you would like access to school health services for your child(ren), during the 2024-25 school year, please complete the consent on the back of this letter and return to your child's school. GCMC Health Services staff cannot provide medical services and/or treatment without written consent.

Examples of health services provided include:

- Medical care and treatment, including diagnosis of acute illness and disease,
- Medically prescribed laboratory tests such as strep tests, and some medications, when appropriate,
- Referrals for service not provided through school health services
- Routine physical examination including those for school, sports, working papers, etc. (Consent not required).
- Communication with child(ren) PCP as needed to support the overall health and wellness

We look forward to partnering with Guthrie for health and wellness for all!

Sincerely,

Joe Mack
Director of Pupil and Personnel Services

Cortland
Enlarged City School District

Health Services Consent

Student name: _____ DOB: _____ Grade: _____

Student name: _____ DOB: _____ Grade: _____

Student name: _____ DOB: _____ Grade: _____

Student name: _____ DOB: _____ Grade: _____

Parent/Guardian Information

Mother/Guardian: _____ Cell/Home: _____ Work: _____

Father/ Guardian: _____ Cell/Home: _____ Work: _____

Parent/Guardian Address: _____

Health Insurance (Please circle and complete, if applicable):

Medical Insurance: ☐ Uninsured ☐ Medicaid ☐ Private Insurance

☐ **Please check here if you would like to be contacted by Guthrie Cortland Medical Center Patient Advocate for assistance with accessing health insurance benefits.**

Student(s) Health Status

Name of Pediatrician _____

List of allergies: medicines, foods, bee stings, etc. Please write child's name with list of allergies or N/A if no allergies.

_____

List of medications your child is currently taking. Please write child's name with list of medications or N/A if no medications.

_____

Has your child been hospitalized in the past year? Y / N. If yes, why? Please list child's name or N/A

_____

Has your child had any surgeries in the past year? Y / N. If yes, describe. Please list child's name or N/A

_____

I authorize Cortland Schools, Guthrie Cortland Medical Center Health Care providers, and my child's primary health care provider to share student information as appropriate to ensure health care can be provided as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; physicals, immunization records, class schedules, parent contact, address, phone number, medical, behavioral and mental health conditions, health screenings, medications, health care plans, or attendance information. I authorize my own provider to also share student information with Cortland Schools, which may include but not be limited to immunization records, physical exam results, health screenings etc. I further grant approval for the health care provider to participate in student health care planning or attendance teams as needed. **This consent will be in effect for one year from this date.**

_____ _____

Parent/Guardian Signature **Date**

Please return the signed, completed form to any school nurse. If you have questions or need assistance, please contact the school nurse.

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

MEDICAID CONSENT NOTIFICATION

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

INTRODUCTION

You are receiving this notification to give you information about your rights and protections under the Federal Individuals with Disabilities Education Act (IDEA), so that you may 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 this legislation.

Funds from an insurance or public benefits program (e.g. 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.

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

MEDICAID CONSENT NOTIFICATION

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

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

MEDICAID CONSENT FORM

Please fill in fields marked with an asterisk (*) even if you DO NOT have Medicaid. This form will be retained in your child's file and will only be used if/when your child receives special education or related services.

The purpose of this form is to ask your permission 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 _____, have received a
Print Name of Parent/Guardian *Print Name of Child*
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 nor my child's 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:

- IEP
- Written Orders/Referrals
- Evaluation Reports
- Session Notes
- Special Transportation Logs
- Medication Administration Reports
- Other Personally Identifiable Information
- Any Other Specific Records Pertaining to the Student's Services or Programs

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 My child is NOT eligible for Medicaid. _____
Initial

Parent Name: _____ Parent Signature: _____

Date: _____

CORTLAND ENLARGED CITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION

CSE/CPSE OFFICE: CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby consent to and authorize Cortland Enlarged City School District
Print Name of Parent/Guardian

to disclose information to or request information from:

_____
Name of Person and Facility - Primary Care Physician

_____ _____
Street Address City State Zip Phone

Regarding: _____ _____ _____
Student's Last Name Student's First Name Student's Date of Birth

Pertaining to: ☒ Academic Records ☒ Medical Records ☒ Social History ☒ Counseling Assessments
☒ Psychological Testing ☒ OT/PT/Speech Scripts ☒ Other: _____

This information is needed for the following purposes:

- ☒ To coordinate services
- ☒ To obtain insurance benefits
- ☒ To obtain government benefits
- ☒ Other: _____

I, _____, understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below. I also understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by the federal privacy rules of New York State law.

Please select one of the following to indicate when this consent should expire:

- ☐ Until services are no longer required
- ☐ A specific date, event or condition upon which it will expire: _____

Parent/Guardian Signature: _____ Date: _____

This consent will expire as indicated above.

PLEASE FORWARD INFORMATION TO:

CSE/CPSE Office
1 Valley View Drive
Cortland, NY 13045
p. (607) 758-4100
f. (607) 758-4144