



NORTH SALEM

CENTRAL SCHOOL DISTRICT

230 June Road • North Salem, New York 10560
(914) 669-5414 • Fax (914) 669-8753

Katherine Daniels
President Board of Education

Kenneth R. Freeston Ph.D.
Superintendent of Schools

Dear Registrant,

Welcome to the North Salem Central School District. We are confident that your child(ren) will have a wonderful educational experience at North Salem.

This packet contains all the necessary forms that you need to complete in order to register your child(ren) in school. If you are registering more than one student, a packet must be completed for each student.

- Student Residency Questionnaire (McKinney-Vento)
- District Records Release Form
- Home Language Questionnaire

In addition to the above, the following information must be provided:

- Birth certificate or baptismal certificate
- Proof of residency (deed, mortgage document)
- If renting, acceptable proof of residency would be a rental agreement with landlord's residency information.
- Health History Form – (All new students require a physical exam within 12 months prior to the date of enrollment) (enclosed)
- Immunization Record (enclosed)
- Proof of guardianship (if applicable)

Once the registration paperwork is complete and reviewed with the District Registrar, an appointment can be made with the appropriate school personnel.

- If the student is enrolled in grades K-5, the appointment should be made with Mrs. Roberta Reiner, Principal of Pequenakonck Elementary School.
- If the student is enrolled in grades 6-12 the appointment should be made with a MS/HS guidance counselor.
- If the student is a pre-schooler, the appointment should be made with Dr. Jean Brickman, CPSE Chairperson.

The District Registrar, Ms. Brigida Favata, is available Monday-Friday, 7 a.m. – 3 p.m. Should you have any questions, please feel free to contact Ms. Favata by calling 669-5414, ext. 2028. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

Kenneth R. Freeston, Ph.D.
Superintendent of Schools

/bf

NORTH SALEM CENTRAL SCHOOL DISTRICT STUDENT INFORMATION AND REGISTRATION FORM

Today's Date _____

Student's Last Name:	First Name:	Middle:
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Date of Birth:	Place of Birth:	Gender:
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Present Grade Level:	Currently attending (please indicate name of school):
If student will be starting school in September, which grade did student just complete?	

If student is transferring from another school, has the "Release of Records" been completed and signed by the parent/guardian? <input type="checkbox"/> yes <input type="checkbox"/> no	Street Address:	
	City:	State/Zip
	Telephone #	Fax #

Has the student received any additional education services? If yes, please indicate:

<input type="checkbox"/> reading room	<input type="checkbox"/> speech therapy	<input type="checkbox"/> physical therapy
<input type="checkbox"/> math remediation	<input type="checkbox"/> occupational therapy	<input type="checkbox"/> language support
<input type="checkbox"/> special education program		
<input type="checkbox"/> social service agencies who support family or child:		
<input type="checkbox"/> other:		

Sibling Information – please include first and last names			
Name:	M/F	Date of Birth	Current School and Grade:

Has this family been previously registered in the North Salem Central School District? yes no

Student's Last Name:			First Name:		Middle:
Student's Residence Address: Street:			Student's mailing address, if different:		
City	State	Zip	City	State	Zip
Student's home telephone number: (please include area code)					
With whom is the student living? (check all that apply) <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other			If the parents are divorced, who has custody?		
			In addition to student's residence, to whom should mail be sent?		
Mother's Name:			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mother's Residence Address Street:			Mother's Mailing Address, if different		
City	State	Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone		
Father's Name:			US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Father's Residence Address Street:			Father's Mailing Address, if different		
City	State	Zip	City	State	Zip
Home Telephone	Cellular		E-mail address		
Highest Level of Education:			Occupation:		
Employer Name/Address			Employer Telephone:		
Stepparent/Guardian Information Name Address City Telephone			Stepparent/Guardian Information Name Address City Telephone		

Parent/Guardian Signature _____ Date: _____

For Office Use Only: Intake by: _____ Proof of Birth: _____ Proof of Residency _____ Health registration complete? _____ Immunization record: _____ Request for Release of Records: _____ Medical Alert? _____ Legal Alert? _____ Student Residency Questionnaire _____
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**NORTH SALEM CENTRAL SCHOOL DISTRICT
STUDENT HEALTH HISTORY AND REGISTRATION FORM**

(To be completed by parent of a student who did not attend North Salem Central School District last year)

Student's Last Name:	First Name:	Middle:
Date of Birth:	Gender:	Grade:

Please record approximate year child had any of the following:

Chicken Pox _____	Ulcers _____	Rheumatic Fever _____
Measles _____	Contact with Tuberculosis _____	Epilepsy _____
Mumps _____	Diabetes _____	Poliomyelitis _____
Whooping Cough _____	Major Fractures _____	High Blood Pressure _____
Heart Disease _____	Extended Illness _____	Ear Problems (tubes?) _____
Lyme Disease _____	Other: _____	

Please provide information about the entries selected above:

Has the child had any surgery, injuries or illnesses requiring hospitalization? No

Yes: please explain _____

Is there any allergy to drugs, foods or stinging insects? No

Yes: please explain _____

Does this child have asthma or hay fever? No

Yes: please explain and include medication information _____

Does this child experience convulsive episodes or fainting spells? No

Yes: please explain _____

Does this child wear glasses? No Yes

If *yes*, are glasses to be worn at all times? No Yes For reading only? No Yes For distance? No Yes

Is this student under treatment or taking medication for any condition at the present time? No

Yes: (please indicate the diagnosis and the name of the medication/dosage/frequency)

Is this student on medication that should be taken during school hours? No

Yes: please explain _____

Is there any other condition for which the Health Office should be made aware? No

Yes: please explain _____

Name of physician: _____ Telephone _____

Signature _____ Date : _____

Please use reverse for additional notes, and check here

Dear Parent/Guardian:

Beginning with the 2010-2011 school year, school districts and states are required to follow new standards in collecting and recording individual-level race and ethnicity data in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students
- Do statistical analysis

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the Student Racial and Ethnic Identification on the reverse side of this page and complete the form for each of your children who will be enrolled in the North Salem Central School.

There are TWO areas that are needed to be checked off on the form.

- √ First, check YES or NO regarding whether or not the child is of Hispanic, Latino or Spanish origin.
- √ Second, check ONE OR MORE of the following choices that are true about the child's ethnicity/race. For example, you would check Asian *and* White for a child that was Asian and White.

North Salem Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If we are unable to get this information from you then, according to State and Federal regulations, we are required to use our own judgment to identify the race and ethnicity of the child. The form may not be blank.

Thank you for your cooperation. If you have any questions, please call your school's principal.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To the Parent/Guardian:

The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) and Regulations of the Chancellor A-820 prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

**PLEASE COMPLETE THE FORM ON THE
REVERSE SIDE OF THIS PAGE**

- All students between 5 and 21 years of age have the right to a free public education
- Children may not be refused admission to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.

Name of School:	
Student Identification Number:	Date of Birth (Month/Day/Year):
Student Name: Last, First, Middle:	Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM CAREFULLY BEFORE YOU RESPOND.

<p>1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race [Check (√) <u>one</u> that best describes your child].</p> <p style="text-align: center;"> <input type="checkbox"/> YES, Hispanic <input type="checkbox"/> NO, not Hispanic </p>
<p>2. Check (√) one or more races from the following five racial groups [Check (√) all groups that apply to your child; check (√) <u>at least ONE</u> box.]:</p> <p><input type="checkbox"/> AMERICAN INDIAN OR ALASKAN NATIVE: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. E.g. Cherokee, Mohawk, Inuit.</p> <p><input type="checkbox"/> 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, the Philippine Islands, Thailand and Vietnam.</p> <p><input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or Other Pacific Islands.</p> <p><input type="checkbox"/> BLACK: A person having origins in any of the Black racial groups of Africa.</p> <p><input type="checkbox"/> WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.</p>

Signature of Parent/Guardian/Other

Date

Relationship to Student:

- Mother
 Father
 Guardian
 Other (Specify) _____

See reverse side for important message to Parent/Guardians and Confidentiality Procedures and Regulations.

NORTH SALEM CENTRAL SCHOOL DISTRICT STUDENT RESIDENCY QUESTIONNAIRE

In compliance with the McKinney-Vento Homeless Education Assistance Act and New York Education Law, every school district is required by the State Education Department's Title I Office to have all new registrants, and all students who change addresses complete a residency questionnaire.

Name of School _____

Name of Student _____ Sex: Male
Last *First* *Middle* Female

Birth Date ____/____/____ Age: ____ Social Security #: _____
Month *Day* *Year* *(or student identification number)*

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.

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

**If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.**

Where is the student currently living? (Check one box)

- In a motel/hotel
- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship
- In a car, park, bus, train or campsite
- Other temporary living situation (Please describe): _____

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

Date

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

Please send a copy to Mary Jo Hauser, Homeless Liaison at the Central Office. (Fax: 914-669-8753)

OFFICE USE ONLY

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date

McKinney-Vento Liaison Signature



Home Language Questionnaire (HLQ)

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT *Please print or type clearly*

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH
Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: Possible LEP
 English Proficient

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ *specify*
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ *specify*
- What language(s) does the student understand? English Other _____ *specify*
- What language(s) does the student speak? English Other _____ *specify*
- What language(s) does the student read? English Other _____ Does Not Read *specify*
- What language(s) does the student write? English Other _____ Does Not Write *specify*
- In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other

Date

Month: Day: Year:



CUESTIONARIO SOBRE EL IDIOMA QUE SE HABLA EN EL HOGAR ("Home Language Questionnaire, HLQ") – Spanish

*Estimado Padre/Madre o Guardián:
Para poder ofrecer a su hijo(a) la mejor educación posible, necesitamos determinar cuán efectivamente él o ella entiende, habla, lee y escribe el idioma inglés. Su ayuda será apreciada si contesta estas preguntas.*

Gracias.

PARA SER COMPLETADO POR EL PERSONAL ESCOLAR (TO BE COMPLETED BY SCHOOL PERSONNEL)

DISTRITO (District)	IMPRIMA O ESCRIBA CLARAMENTE (Please print or type Clearly)		
ESCUELA (School)	GRADO (Grade)		
NOMBRE DEL ESTUDIANTE (Student Name)			
FECHA DE NACIMIENTO (Date Of Birth)			
Mes: (Month)	Día: (Day)	Año: (Year)	
NUMERO DE IDENTIFICACION DEL ESTUDIANTE (Student Identification Number)			
PAIS NATAL O ASCENDENCIA (Country of Birth/Ancestry)			
NUMERO DE AÑOS MATRICULADO EN ESCUELA(S) FUERA DE LOS E.U. (Number of years enrolled in school outside the U.S.)			
NOMBRE/POSICIÓN DEL PERSONAL ESCOLAR LLENANDO ESTA SECCION (Name/Position School Personnel Completing This Section)			
DETERMINACIÓN: (Determination)			
		<input type="checkbox"/> Posiblemente LEP (Possibly LEP)	
		<input type="checkbox"/> Dominante en Inglés (English Proficient)	

(✓ Marque las casillas que aplican)

- ¿Qué idioma(s) se habla en el hogar o residencia del estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿En qué idioma(s) se le habla al estudiante la mayor parte del tiempo en el hogar o residencia? Inglés Español Otro _____
(Especifique cuál)
- ¿Qué idioma(s) entiende el estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿Qué idioma(s) habla el estudiante? Inglés Español Otro _____
(Especifique cuál)
- ¿En qué idioma(s) lee el estudiante? Inglés Español Otro _____ No lee
(Qué idioma)
- ¿En qué idioma(s) escribe el estudiante? Inglés Español Otro _____ No escribe
(Qué idioma)
- ¿En su opinión, qué tan bien el estudiante entiende, habla, lee y escribe inglés?

	Muy bien	Un poco	Nada
Entiende Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Habla Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lee Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Escribe Inglés	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH CERTIFICATE / APPRAISAL FORM

Rec'd _____
Appr _____

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

<input type="checkbox"/> Immunization record attached <input type="checkbox"/> No immunizations given today <input type="checkbox"/> Immunizations given since last Health Appraisal: _____	Sickle Cell Screen: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ PPD: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done Date: _____ Elevated Lead: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____ Dental Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done Date: _____
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Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure/Pulse: _____ Date of Exam: _____
Referral

Body Mass Index: _____ . _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: none;">Vision - without glasses/contact lenses</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Vision - with glasses/contact lenses</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Vision - Near Point</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="border: none;">R</td> <td style="border: none;">L</td> <td style="border: none;"></td> </tr> </table>	Vision - without glasses/contact lenses	R	L		Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
Vision - without glasses/contact lenses	R	L															
Vision - with glasses/contact lenses	R	L															
Vision - Near Point	R	L															
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear Other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

North Salem Central School District Immunization Record

Student's Name _____

Date of Birth _____

	Date	Date	Date	Date	Date
Polio (IPV or OPV)					
Diphtheria (DTaP/DTP/DT/TD)					
Tetanus, Diphtheria and Pertussis Booster (Tdap)					
Measles, Mumps and Rubella (MMR)					
Hepatitis B					
HiB					
PCV					
Varicella					
TB Test					
Menactra					

Doctor's Signature _____

Date _____



NORTH SALEM

Central School District

230 June Road * North Salem * NY * 10560

PERMISSION TO RECEIVE/RELEASE RECORDS

I give permission for the North Salem Central School District to receive all educational, psychological and medical records pertaining to my child. This includes Transcripts, Report Cards, Attendance Records, Disciplinary Records and, if applicable, IEP (If the child has been identified by the Committee on Special Education, the IEP, handicapping condition, past placement, medical, psychological and physical histories should also be provided).

Name of Student	Current Grade	Date of Birth
-----------------	---------------	---------------

Please send a copy of the checked records:

- IEP
- Transcript
- Report Card
- Current Schedule
- Attendance Records
- Disciplinary Records

Please send a copy of the above student's records to the school indicated below:

North Salem Middle/High School
 230 June Road
 North Salem, NY 10560
 914-669-5414
 914-669-5663 (fax)

Pequenakonck Elementary School
 173 June Road
 North Salem, NY 10560
 914-669-5317
 914-669-4326 (fax)

I, _____, request my child's records to be released to the above school.
Parent/Guardian SIGNATURE