



MIDDLEBURGH CENTRAL SCHOOL DISTRICT

Registration Packet Includes:

- ▶ Request for Student Records
- ▶ Registration Form
- ▶ Educational History
- ▶ Child Development & Medical History
- ▶ NYS Health Examination Form
- ▶ Dental Health Certificate
- ▶ Medication Permission Form
- ▶ Proof of Residency/Housing
- ▶ Home Language Questionnaire
- ▶ Technology Use Forms/Handbook
 - Student Acknowledgment Form
 - Parent/Guardian Acknowledgment Form
 - Acceptable Use Policy Form
- ▶ Student Handbook & Signature Page
- ▶ Transportation Form
- ▶ Application for Free/Reduced School Meals

In order to complete registration (this includes UPK programs) the following documents must be provided:

- ☐ Parent/Legal Guardian Photo ID
 - ☐ Valid State Issued ID or Valid Passport
- ☐ Proof of Residency
 - ☐ Must provide TWO acceptable forms of proof:
 - ☐ Utility bill, official payroll document or letter from a federal, state or local government agency, current property tax bill, copy of signed lease agreement
- ☐ Birth Certificate
 - ☐ Original (we will make a copy) or Certified Copy or Valid Passport
- ☐ Proof of Immunization
 - ☐ Must be signed or stamped by a state licensed health care provider
- ☐ Custody Papers (if Applicable)
- ☐ Special Circumstances (Residency Questionnaire)
 - ☐ If applicable, detailing legal guardianship situations, temporary living situations, custody agreements, name changes

MIDDLEBURGH CENTRAL SCHOOL DISTRICT

Request for Student Records

(Previous School District)

Please be advised that the following student, previously enrolled in your school, has transferred to the Middleburgh Central School District.

I hereby authorize the following information to be sent to the school indicated below.

Student's Name (First, Middle, Last)	Gender	Date of Birth	Grade Level:

Requested Records:

- | | |
|------------------------------------|--|
| ▶ Academic Transcripts/Report Card | ▶ Regents and RCT Scores |
| ▶ Individualized Education Plans | ▶ Functional Behavioral Assessments |
| ▶ 504 Plans | ▶ Social Work |
| ▶ Health and Immunizations | ▶ Record of Birth |
| ▶ State Test Scores | ▶ Discipline |
| ▶ Standardized Test Scores | ▶ Other pertinent information to ensure proper placement |

Please Fax the information requested to:

Laurie McGeary

Email: Laurie.McGeary@mcsdny.org

Phone: (518)827-3600 Ext. 2601

Fax: (518)827-5181

Parent/Guardian Signature: _____ Date: _____

Middleburgh Central School District

Registration Form

Please Choose the appropriate program according to date of birth*:

- ☐ 3 Year Old UPK (3 by12/1) AM / PM
 ☐ 4 Year Old UPI<(4 by12/1) AM / PM
☐ Kindergarten (5 by12/1)
 ☐ *My child will be attending AM Head start
☐ Grade_____

Student's Name:_____ Middle Initial____ Last Name:_____

Gender:_____ Date of Birth:_____ Primary Language:_____

Is Hispanic? (Optional) ☐Yes ☐No

Race (Optional): ☐White ☐Black or African American ☐Asian ☐American Indian or Alaskan Native
☐Native Hawaiian/Other Pacific Islander

Mailing Address: _____

Physical Address: _____

Student's Home Phone: _____ Student's Cell Phone: _____

Parent/Guardian Information:

Student resides with: ☐Parents ☐Mother ☐Father ☐Foster Parents (please see attached form DSS-299) ☐

Other Are there Legal Arrangements: ☐No ☐Yes If yes, please provide court documents

☐Joint Custody ☐Sole Custody ☐Temporary Custody ☐Visitation

Primary Parent/Guardian Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Workplace: _____ Work Phone: _____

Choose All that Apply to above person:

Receives Mail ☐Can Pick Up ☐Custody Alert ☐Allow Parent Portal Access ☐Restricted

Primary Parent/Guardian Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Work Place: _____ Work Phone: _____

Choose All that Apply to above person:

☐Receives Mail ☐Can Pick Up ☐Custody Alert ☐Allow Parent Portal Access ☐Restricted

List all Siblings that live in household	Gender	Birthdate	Grade	School

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

*Please note preferences for am or pm does not guarantee placement. Final placement will be determined by district and you will be informed by mail of your child's placement.

Middleburgh Central School District

Educational History

Student Name: _____

Has the student previously attended School in the Middleburgh Central School District?

☐ Yes ☐ No

If Yes, which school: _____

Does the student have an IEP (Individual Education Plan)?

☐ Yes ☐ No

Does the student have a 504 Plan?

☐ Yes ☐ No

Has the student participated in any of the following programs? *Check all that apply*

☐ Academic Intervention Service ☐ Reading Services

☐ Math Services ☐ Other: _____

Please Check any special programs that your child has been assigned to in the past:

☐ Consultant Services

☐ Resource Room

☐ Bilingual Education

☐ Special Classes

☐ Occupational Therapy

☐ Speech Therapy

☐ Physical Therapy

☐ Counseling

☐ Other:

UPK Parents Only:

Did your child attend:

☐ UPK-3

Location: _____

☐ Head Start

Location: _____

Please list all previous schools beginning with most recent:

Name of School: _____

Address:

Phone:

Name of School:

Address:

Phone:

Name of School:

Address:

Phone:

Child Developmental & Medical History

Student's Name:	Grade: M/F Date of Birth:
Birth:	Developmental:
Term: Weight:	First Tooth Age: Sat Alone Age:
Delivery:	Crawled Age: Walked Age:
Conditions:	Talked at Age:
Abnormalities:	

1. Were problems experienced during pregnancy which required medical intervention? If yes, what were they:

2. Were there any complications at birth? (*premature, prolonged labor, need for oxygen, difficult delivery*):

3. Please note any congenital conditions present at birth:

4. Did your child proceed through developmental stages normally?

5. Were there any particular difficulties as a preschooler? (*Difficulty watering, sleeping, bedwetting, etc*)

6. Any diseases, illnesses, or injuries which required medical attention?

7. Any undiagnosed illnesses? (*Prolonged high fever, convulsions, seizures, etc.*)

8. Any hospitalizations? If so, for what reason?

9. Has your child had surgery for any reason? If yes, when and for what?

10. Have hearing or visual aides ever been required for your child? If yes, when and what for?

11. Has your child been on medication for any reason?

12. Have there been any neurological problems diagnosed on your child, birth to present? If so, please explain:

13. Attention problems or hyperactivity problems? Has medication been prescribed? If yes, what med and when started? _____
14. Previous or current cancer treatments? Please explain:

15. Please explain any other pertinent medical, dental or psychological history:

16. Is your child a twin? If yes, birth order: Twin 1 _____ Twin 2 _____

Child Developmental & Medical History

Has your child had the following? (Please check ☒ and list date(s)):

Illness	<input checked="" type="checkbox"/>	Date	Illness	<input checked="" type="checkbox"/>	Date
Chicken Pox	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	
Scarlet Fever	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>		Seizures (List Type)	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	
Breathing Difficulties	<input type="checkbox"/>		Allergy to bee stings	<input type="checkbox"/>	
Blood Disorders	<input type="checkbox"/>		Family history of bee allergy**	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>		Frequent Ear Infections/Aches	<input type="checkbox"/>	
Kidney Problems	<input type="checkbox"/>		Frequent Colds	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>		Frequent Strep Throat	<input type="checkbox"/>	
Family History of TB	<input type="checkbox"/>		Ear Condition	<input type="checkbox"/>	
Contact with TB	<input type="checkbox"/>		Ear Tubes	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>		Vision Difficulties	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>		Cataracts	<input type="checkbox"/>	
Scoliosis	<input type="checkbox"/>		Speech Difficulties	<input type="checkbox"/>	
Frequent Nosebleeds	<input type="checkbox"/>		Emotional Problems	<input type="checkbox"/>	
Food Allergies (Please List)	<input type="checkbox"/>		Behavioral Problems	<input type="checkbox"/>	
Lactose Intolerant	<input type="checkbox"/>		Frequent Headaches	<input type="checkbox"/>	
other	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	
			**Type of reaction to Bee Sting:		

Regarding Allergies:

Does your child have allergies: ☐ Yes ☐ No If yes, what allergies? _____

Does your child require medication for allergies? ☐ Yes ☐ No If yes, what medication? _____

Does your child require medication to stay in school? ☐ Yes ☐ No If yes, what medication? _____

Please note: regarding medications in school, both a signed doctor's note and a parent note are required in order for the school nurse to administer medications.

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Parent Signature: _____ **Date:** _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI _____ kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)

ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions. If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Dental Health Certificate- OPTIONAL

Parent/Guardian: New York State Law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist/dental hygienist to fill out Section 2. Return the completed for to the schools medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (PLEASE PRINT)

Child's Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Will this be their first oral health assessment: ☐ Yes ☐ No

School Name: _____ Grade: _____

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities:

☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing, or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent/Guardian Signature: _____ Date: _____

Section 2. To be completed by the Dentist/Dental Hygienist

I. The dental health condition of _____ on _____ (date of assessment). The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one of the following:

☐ Yes, the student listed above is in fit condition of dental health to permit his/her attendance at the public school.

☐ No, the student listed above is not in fit condition of dental health to permit his/her attendance at the public school.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with the student's ability to chew, speak, focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/Dental Hygienist's Name and Address:

(Please Print or Stamp)

Dentist's/Dental Hygienist's Signature:

Optional Sections - If you agree to release this information to your child's school, please initial here: _____

II. Oral Health Status (Check all that apply)

☐ Yes ☐ No **Caries Experience/Restoration History** - Has the child ever had a cavity (treated or untreated)? { A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity }

☐ Yes ☐ No **Untreated Caries** - Does the child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.]

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify): _____

II. Treatment Needs (Check all that apply):

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please Schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

School Health Services

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child _____ (Date of birth: _____) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature

(Parent or Guardian): _____ Date _____

Telephone: Home _____ Work _____

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any): _____

Healthcare Provider's Signature _____ Date _____

Address: _____ Phone: _____

**Medication must be in the original pharmacy labeled container with specific orders and name of medication.*

**Medication and refills must be brought to school by parent, guardian, or responsible adult:*

This medication order is valid for the current school year and summer school as needed.

SCHOOL NURSES' OFFICE FAX
Jr./Sr. High School: (518) 827-5162
Elementary School: (518) 827-3289

Middleburgh Central School District

Proof of Residency/Housing

Name of Student: _____

If registering more than one student, you can list them below.

Student:	Gender:	Date of Birth:	Grade:

Please check one:	<input type="checkbox"/> Own	<input type="checkbox"/> Reside with a district resident
	<input type="checkbox"/> Rent	<input type="checkbox"/> Temporary living situation

To enroll you must reside within the district. Solely owning property or a home does not constitute residency. Proof of residency is required before a student may be registered. Post office boxes will not be accepted. You must provide at least two (2) proofs from the following list:

<i>If you own:</i>	<i>If you rent:</i>
<input type="checkbox"/> Tax Bill within 30 days	<input type="checkbox"/> Documents issued by the federal, state or local agencies
<input type="checkbox"/> House Deed	<input type="checkbox"/> Lease agreement (<i>must be signed with the landlord's name and phone number</i>)
<input type="checkbox"/> Mortgage Statement within 30 days	<input type="checkbox"/> Current Renter's Insurance
<input type="checkbox"/> Current Homeowner's Insurance	
<input type="checkbox"/> Utility Bill within 30 days	
<input type="checkbox"/> Voter Registration	

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 certificates. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

<i>Where is the Student currently living?</i>
<input type="checkbox"/> In a shelter
<input type="checkbox"/> With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up").
<input type="checkbox"/> In a hotel/motel
<input type="checkbox"/> In a car, park, bus, train, or campsite
<input type="checkbox"/> Other temporary living situation (Please describe):
<input type="checkbox"/> In Permanent housing

This document will be retained in the student's file along with other required documents. Once this form is received by the District Registrar, residency will be verified.

Parent/Guardian Signature: _____ Please Print Name: _____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

Office of P12

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:		
<i>First</i>	<i>Middle</i>	<i>Last</i>
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to</i>

HOME LANGUAGE CODE

--

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1 _____ <input type="checkbox"/> Guardian(s) _____	<input type="checkbox"/> Parent 2 _____ <input type="checkbox"/> _____
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> 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

Relationship 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: ☐ Yes ☐ No

**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:

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

☐ ENTERING

☐ EMERGING

☐ TRANSITIONING

☐ EXPANDING

☐ COMMANDING

MO. DAY YR.

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

OFFICE USE ONLY

Date Received: _____

Date Approved: _____

Middleburgh Central School District
Transportation Department
Alternate Transportation/Emergency Closing Form/Parent Transportation

School Year: _____

Effective Date: _____

I am requesting transportation for my child/children to the location below:

Child's Name	School Building	Grade/Teacher

Please transport my child/children to:

Home Address: _____

Home Phone: _____

Alternate Location

_____ Home/Legal Residence Bus Number

_____ Number Alternate Location Bus Number

Circle All that Apply:

Monday	AM Only	PM Only	AM/PM	As Needed
Tuesday	AM Only	PM Only	AM/PM	As Needed
Wednesday	AM Only	PM Only	AM/PM	As Needed
Thursday	AM Only	PM Only	AM/PM	As Needed
Friday	AM Only	PM Only	AM/PM	As Needed

IF ALTERNATE LOCATION IS NOT USED ON A CONSISTENT BASIS, THEN A BUS NOTE MUST BE SUBMITTED EVERY TIME THE ALTERNATE ROUTE WILL BE USED

PARENT TRANSPORT: Student(s) will not need district provided transportation for the _____ School Year:

☐ Parent Transport

Parent/Guardian Print Name

Home Phone

Physical Address

Emergency Phone

Parent/Guardian Signature

Date

Google Workspace for Education Permission

To parents and guardians,

At Middleburgh Central School District, we use Google Workspace for Education, and we are seeking your permission to provide and manage a Google Workspace for Education account for your child. Google Workspace for Education is a set of education productivity tools from Google including Gmail, Calendar, Docs, Classroom, and more used by tens of millions of students and teachers around the world. At Middleburgh Central School District, students will use their Google Workspace for Education accounts to complete assignments, communicate with their teachers, and learn 21st century digital citizenship skills.

The notice below provides answers to common questions about what Google can and can't do with your child's personal information, including:

What personal information does Google collect?

How does Google use this information?

Will Google disclose my child's personal information?

Does Google use student personal information for users in K-12 schools to target advertising?

Can my child share information with others using the Google Workspace for Education account?

Please read it carefully, let us know of any questions, and then sign below to indicate that you've read the notice and give your consent. If you don't provide your consent, we will not create a Google Workspace for Education account for your child.

I give permission for Middleburgh Central School District to create/maintain a Google Workspace for Education account for my child and for Google to collect, use, and disclose information about my child only for the purposes described in the notice below.

Thank you,

Matthew Sloane

Jr.-Sr. High School Principal

Full name of student

Grade

Printed name of parent/guardian

Signature of parent/guardian

Date

Google Workspace for Education Notice to Parents and Guardians

This notice describes the personal information we provide to Google for these accounts and how Google collects, uses, and discloses personal information from students in connection with these accounts.

Using their Google Workspace for Education accounts, students may access and use the following “Core Services” offered by Google (described at https://workspace.google.com/terms/user_features.html):

Gmail	Currents	Calendar	Chrome Sync	Classroom	Cloud Search
Contacts	Docs	Sheets	Slides	Forms	Drive
Groups	Hangouts	Chat	Meet	Talk	Jamboard
Keep	Sites	Vault			

In addition, we also allow students to access certain other Google services with their Google Workspace for Education accounts. Specifically, your child may have access to “Additional Services” including, but not limited to:

YouTube	Google Photos
Google Earth	Google Books
Google Maps	Extensions from the Chrome Webstore

Google provides information about the information it collects, as well as how it uses and discloses the information it collects from Google Workspace for Education accounts in its Google Workspace for Education Privacy Notice. You can read that notice online at https://workspace.google.com/terms/education_privacy.html. You should review this information in its entirety, but below are answers to some common questions:

What personal information does Google collect?

When creating a student account, Middleburgh Central School District may provide Google with certain personal information about the student, including, for example, a name, email address, and password. Google may also collect personal information directly from students, such as telephone number for account recovery or a profile photo added to the Google Workspace for Education account.

When a student uses Google services, Google also collects information based on the use of those services. This includes:

device information, such as the hardware model, operating system version, unique device identifiers, and mobile network information including phone number; log information, including details of how a user used Google services, device event information, and the user's Internet protocol (IP) address; location information, as determined by various technologies including IP address, GPS, and other sensors; unique application numbers, such as application version number; and cookies or similar technologies which are used to collect and store information about a browser or device, such as preferred language and other settings.

How does Google use this information?

In Google Workspace for Education Core Services, Google uses student personal information to provide, maintain, and protect the services. Google does not serve ads in the Core Services or use personal information collected in the Core Services for advertising purposes.

In Google Additional Services, Google uses the information collected from all Additional Services to provide, maintain, protect and improve them, to develop new ones, and to protect Google and its users. Google may also use this information to offer tailored content, such as more relevant search results. Google may combine personal information from one service with information, including personal information, from other Google services.

Does Google use student personal information for users in K-12 schools to target advertising?

No. For Google Workspace for Education users in primary and secondary (K-12) schools, Google does not use any user personal information (or any information associated with a Google Workspace for Education Account) to target ads, whether in Core Services or in other Additional Services accessed while using an Google Workspace for Education account.

Can my child share information with others using the Google Workspace for Education account?

We may allow students to access Google services such as Google Docs and Sites, which include features where users can share information with others or publicly. When users share information publicly, it may be indexable by search engines, including Google.

Will Google disclose my child's personal information?

Google will not share personal information with companies, organizations and individuals outside of Google unless one of the following circumstances applies:

With parental or guardian consent. Google will share personal information with companies, organizations or individuals outside of Google when it has parents' consent (for users below the age of consent), which may be obtained through Google Workspace for Education schools.

With Middleburgh Central School District. Google Workspace for Education accounts, because they are school-managed accounts, give administrators access to information stored in them.

For external processing. Google may provide personal information to affiliates or other trusted businesses or persons to process it for Google, based on Google's instructions and in compliance with the Google Workspace for Education privacy notice and any other appropriate confidentiality and security measures.

For legal reasons. Google will share personal information with companies, organizations or individuals outside of Google if it has a good-faith belief that access, use, preservation or disclosure of the information is reasonably necessary to:

meet any applicable law, regulation, legal process or enforceable governmental request.

enforce applicable Terms of Service, including investigation of potential violations.

detect, prevent, or otherwise address fraud, security or technical issues.

protect against harm to the rights, property or safety of Google, Google users or the public as required or permitted by law.

Google also shares non-personal information -- such as trends about the use of its services -- publicly and with its partners.

What choices do I have as a parent or guardian?

First, you can consent to the collection and use of your child's information by Google. If you don't provide your consent, we will not create a Google Workspace for Education account for your child, and Google will not collect or use your child's information as described in this notice.

If you consent to your child's use of Google Workspace for Education, you can access or request deletion of your child's Google Workspace for Education account by contacting Elementary Principal Amy Irwin or Jr-Sr High School Principal Matthew Sloane. If you wish to stop any further collection or use of your child's information, you can request that we use the service controls available to limit your child's access to features or services, or delete your child's account entirely. You and your child can also visit <https://myaccount.google.com> while signed in to the Google Workspace for Education account to view and manage the personal information and settings of the account.

What if I have more questions or would like to read further?

If you have questions about our use of Google's Google Workspace for Education accounts or the choices available to you, please contact Elementary Principal Amy Irwin or Jr-Sr High School Principal Matthew Sloane. If you want to learn more about how Google collects, uses, and discloses personal information to provide services to us, please review the [Google Workspace for Education Privacy Center](https://www.google.com/edu/trust/) (at <https://www.google.com/edu/trust/>), the [Google Workspace for Education Privacy Notice](https://workspace.google.com/terms/education_privacy.html) (at https://workspace.google.com/terms/education_privacy.html), and the [Google Privacy Policy](https://www.google.com/intl/en/policies/privacy/) (at <https://www.google.com/intl/en/policies/privacy/>).

The Core Google Workspace for Education services are provided to us under [Google Workspace for Education Agreement](https://www.google.com/apps/intl/en/terms/education_terms.html) (at https://www.google.com/apps/intl/en/terms/education_terms.html)



MIDDLEBURGH CENTRAL SCHOOL DISTRICT
291 Main Street – P.O. Box 606
Middleburgh, New York 12122
(518) 827-3600 x 2605

Student: Acknowledgment Form

I hereby acknowledge and accept full responsibility, including damage/loss/theft, for this Dell Latitude 3100 Chromebook and power cord for the duration of the student's enrollment in the Middleburgh Central School District.

This device is only for student use with the "MCSDNY.org" district-provided Google account. As such, content accessed with this device is **always** filtered using *Lightspeed Systems* for inappropriate material and uses not meant for educational purposes.

Data Privacy and Security Considerations for Families:

By signing below, I am acknowledging that I have read and will comply with the *Middleburgh Central Technology Use Agreement Handbook* and [School District Acceptable Use Policy](#) (BOE Policy – [7316](#)).

** This device is the property of the Middleburgh Central School District and if not returned will be disabled and unusable. ***

Device: One (1) Dell Latitude 3100 Chromebook and One (1) Charger

Service Asset Tag/Serial #:

Student Name: _____

Student Signature: _____

Date: _____

Student ID#: _____

Grade Level: _____

Middleburgh 1:1 Computer Consent Form

Parent /Guardian: Acknowledgment

By accepting this device from the Middleburgh Central School District, you are agreeing to the terms in this agreement. You acknowledge that you have read and will comply with the *Middleburgh Central School District Technology Use Agreement Handbook and School District Acceptable Use Policy (BOE Policy – 7316)*.

These are the estimated costs of the most common repairs:

- Broken screen \$250
- Cracked case (laptop body) \$75
- Replacement keyboard \$75
- Broken or lost charger \$35
- Broken AC adapter port \$50
- Device replacement \$475

The Middleburgh Central School District is sponsoring an optional Device Service Plan for a fee of \$20 per school year. Coverage includes:

- First Claim: Free of charge service with optional Device Service Plan
 - What is covered: One accidental damage of the device if the cost to fix the damage is less than \$75, or \$75 deducted from the bill if the repair cost more.
 - What is not covered: Misuse, neglect, intentional damage and loss
- Additional Claims: User is responsible for the full cost of the repairs or replacement.

Payments for the Device Service Plan can be made via check or cash – payable to: Middleburgh Central School District.

In the event of theft, a claim must be accompanied by a Police Report for the device to be replaced.

Device Borrowing Terms

- Students must return their device at the end of each academic year for inspection, software updates, and maintenance. The same device will be issued back to the student at the start of the next school year.
- Students are not to add unauthorized programs, apps or software not approved by the Middleburgh Central School District
- Students are not to remove the device asset tag.

To Report a Claim or damage

Bring your device to the Library Media Center to have an IT Ticket submitted. If your device is lost, report it to Jody DeJong in the Library Media Center.

Payments or lost or broken devices

Bills for repairs are sent out monthly during the school year, and in July for the end of the school year. Payments for repair/replacement can be made via check or cash – payable to: Middleburgh Central School District.

Parent / Guardian Name: _____

Student Name: _____

Parent Signature: _____

Date: _____

MIDDLEBURGH SCHOOL DISTRICT STUDENT ACCEPTABLE USE POLICY

In consideration for the use of the Middleburgh School District's Computer System (DCS), I agree that I have been provided with a copy of the District's policy on student use of computerized information resources and the regulations established in connection with that policy. I agree to adhere to the policy and the regulations and to any changes or additions later adopted by the District. I also agree to adhere to related policies published in the Student Handbook.

I understand that failure to comply with these policies and regulations may result in the loss of my access to the DCS. Prior to suspension or revocation of access to the DCS, students will be afforded applicable due process rights. Violation of District policy and regulations may also result in the imposition of discipline under the District's school conduct and discipline policy and the *Code of Conduct*. I further understand that the District reserves the right to pursue legal action against me if I willfully, maliciously, or unlawfully damage or destroy property of the District. Further, the District may bring suit in civil court in accordance with General Obligations Law Section 3-112 against my parents or guardians if I willfully, maliciously, or unlawfully damage or destroy District property.

Student Signature: _____

Grade level: _____

Date: _____

MIDDLEBURGH SCHOOL DISTRICT PARENT OR GUARDIAN NOTIFICATION OF STUDENT ACCEPTABLE USE POLICY

I am the parent or guardian of _____,
the minor student who has signed the District's agreement for student use of computerized information resources. I have been provided with a copy and I have read the District's policy and regulations concerning use of the DCS.

I also acknowledge receiving notice that, unlike most traditional instructional or library media materials, the DCS will potentially allow my child student access to external computer networks not controlled by the Middleburgh School District. I understand that some of the materials available through these external computer networks may be inappropriate and objectionable; however, I acknowledge that it is impossible for the District to screen or review all of the available materials. I accept responsibility to set and convey standards for appropriate and acceptable use of technology to my child when he or she is using the DCS or any other electronic media or communications, including my child's own personal technology or electronic device on school grounds or at school events.

I agree to release the Middleburgh School District, the Board of Education, its agents and employees from any and all claims of any nature arising from my child's use of the DCS in any manner whatsoever. I agree that my child will have access to the DCS and I agree that this may include remote access from our home.

Parent or Guardian Signature: _____

Student's Name: _____

Date: _____

Middleburgh Junior-Senior High School
2023-2024

SIGNATURE PAGE

(Please complete and return)

- ☐ **STUDENT HANDBOOK** By checking this box and signing below, both the parent/legal guardian and the student acknowledge receiving a copy of the Middleburgh Central School Handbook and have read, discussed and understand the contents of this handbook.

- ☐ **INTERNET SAFETY/STUDENT ACCEPTABLE USE POLICY/STUDENT USE OF PERSONAL TECHNOLOGY** (BOARD OF EDUCATION POLICY NUMBERS 8271, 7315 AND 7316) by checking this box and signing below, both the parent/legal guardian and the student acknowledge reading the “Internet Safety/Internet Content Filtering Policy” and the “Acceptable Use Policy”. Both the parent/legal guardian and the student understand the policies and agree to abide by their requirements.

- ☐ **GOOGLE WORKSPACE FOR EDUCATION PERMISSION** By checking this box you are acknowledging the use of Google platforms that are outside of the general education products. This includes Google Maps, Google Earth, Google Photos, Google Books, Extensions from the Chrome Web Store and YouTube.

- ☐ **ATTENDANCE POLICY** By checking this box and signing below, both the parent/legal guardian and the student acknowledge that the Attendance Policy has been read and understood.

- ☐ **CELL PHONE POLICY** By checking this box I understand that cell phones are not to be used during the school day, except during your designated lunch period. Consequences will be given if this policy is not followed.

Sign on the back and return to your homeroom teacher or main office.

I have read and acknowledged the permissions and policies for the 2023-2024 school year.

Print name of student: _____

Signature of student: _____

Print name of parent: _____

Signature of parent: _____

Date: _____