# 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 (Optional)
- Proof of Residency/Housing
- Home Language Questionnaire
- Transportation Form
- Migrant Survey
- Technology Acceptable Use Forms

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

Please Fax the information requested to:

Academic Records/Medical:
Laurie McGeary
Email: Laurie.McGeary@mcsdny.org
Phone: (518)827-3600 Ext. 2601
Fax: (518)827-5181

IEP/504:
Ellen Miller
Email: Ellen.Miller@mcsdny.org
Phone: (518)827-3600 ext 3681
Fax: (518)827-4115

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

**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: ☐ Female ☐ Male | Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X | |
| School: | Grade: | Exam Date: |

**HEALTH HISTORY**

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

| | |
|---|---|
| ☐ **Allergies** | Type:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| ☐ **Asthma** | ☐ Intermittent ☐ Persistent ☐ Other:<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| ☐ **Seizures** | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| ☐ **Diabetes** | Type: ☐ 1 ☐ 2<br>☐ Medication/Treatment Order Attached ☐ 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 | Date |
|---|---|---|---|---|---|
| TB- PRN | ☐ | ☐ | | ☐ Test Done ☐ Lead Elevated ≥5 µg/dL | |
| Sickle Cell Screen-PRN | ☐ | ☐ | | | |

☐ **System Review Within Normal Limits**

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

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine/Neck | ☐ Skin | ☐ Social Emotional |
| ☐ Mental Health | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ 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** ☐Yes ☐ No | **Right** | **Left** | **Referral** | **Not Done** |
|---|---|---|---|---|---|
| Distance Acuity | | 20/ | 20/ | ☐ Yes | ☐ |
| Near Vision Acuity | | 20/ | 20/ | | ☐ |
| Color Perception Screening | ☐ Pass ☐ Fail | | | | ☐ |

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** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes | ☐ |

Notes

| **Scoliosis** Screening: Boys grade 9, Girls grades 5 & 7 | **Negative** | **Positive** | **Referral** | **Not Done** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ Yes | ☐ |

**FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK**

☐ ***Family cardiac history reviewed –** required for Dominic Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

**If Restrictions Apply –** Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

**Developmental Stage for Athletic Placement Process ONLY 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:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

**MEDICATIONS**

☐ Order Form for medication(s) needed at school attached

| **COMMUNICABLE DISEASE** | **IMMUNIZATIONS** |
|---|---|
| ☐ Confirmed free of communicable disease during exam | ☐ Record Attached ☐ Reported in NYSIIS |

**HEALTHCARE PROVIDER**

| Healthcare Provider Signature: | |
|---|---|
| Provider Name: *(please print)* | |
| 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 the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.**

## Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's 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's 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:**

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

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

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or 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 this 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 that 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.

Middleburgh CENTRAL SCHOOL DISTRICT

# Housing Questionnaire

Name of Student: _____

Physical Address: _____

Student resides with ❒**Parents** ❒**Mother** ❒**Father** ❒**Guardian** ❒ **Other:** _____

If registering more than one, please list their names below:

| Student Name | Gender | Date of Birth | Grade |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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.*)**

- With another family/person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train or campsite
- Other temporary living situations (please describe): _____
- In permanent housing (*submit 2 Proofs of Residency from list below*)

**If you own please provide 2 of the following:**

- Tax bill within 30 days
- House Deed
- Mortgage Statement within 30 days
- Current Homeowner's Insurance
- Utility Bill within 30 days
- Voter Registration

**If you rent please provide 2 of the following:**

- Documents issued by federal, state or local agencies
- Utility bill within 30 days
- Lease agreement (*must be signed and notarized with the landlord's name and phone number)*
- Current renter's insurance

Print Parent Name: _____

Parent Signature: _____

Date: _____

**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:**

*First* *Middle* *Last*

**DATE OF BIRTH:**

*Month* *Day* *Year*

**GENDER:**

❑ Male
❑ Female

**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: | |
| **2. What was the first language your child learned?** | ❑ English | ❑ Other: | |
| **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: | |
| **5. What language(s) does your child speak?** | ❑ English | ❑ Other: | ❑ Does not speak |
| **6. What language(s) does your child read?** | ❑ English | ❑ Other: | ❑ Does not read |
| **7. What language(s) does your child write?** | ❑ English | ❑ Other: | ❑ 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:* | |

## *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:**
MO. DAY YR.

**PROFICIENCY LEVEL ACHIEVED ON NYSITELL:** ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

**Check 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

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

# IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

***Please take a few minutes to complete this questionnaire.***

## Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)

☐ Work related to logging, harvesting, or initial processing of trees.

☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

***If you answered YES, please provide your contact information below:***

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

**To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.**

# MCS Student Acceptable Use Policy (AUP) 7315 – Abridged

**The full, unabridged version of this policy is available at:**
**https://go.boarddocs.com/ny/middleburghcsd/Board.nsf/goto?open&id=AWL4FU0B66F4**

## Purpose

The Middleburgh Central School District (MCSD) is committed to leveraging technology to enhance teaching, learning, and student engagement. This policy governs student use of the District's digital resources, including internet access, electronic devices, and network systems, to ensure safe, responsible, and ethical use in alignment with the District's educational mission.

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## 1. Scope

This policy applies to:

- All students using the District Computer System (DCS), which includes hardware, software, networks, cloud services, and electronic communication platforms.
- Both school-owned and personally-owned devices (BYOD) used on school property or connected to District networks.
- All use of digital tools in both on-campus and remote settings.

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## 2. Access to Digital Resources

- Student access to the internet and online services is a privilege provided for educational purposes.
- The District uses content filtering, monitoring, and security protocols to protect users, though it cannot guarantee full control over all digital content.
- Students may be granted remote access to school platforms; these uses are still subject to the AUP.

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## 3. Expectations for Responsible Use

Students must:

- Use technology in ways that are safe, ethical, respectful, and educational.
- Respect privacy, intellectual property, and copyright laws.
- Protect personal information (e.g., full name, address, phone number, images) online.
- Use digital tools to support academic success, not to disrupt learning environments.

Examples of **prohibited behaviors** include but are not limited to:

1. Accessing, creating, or distributing inappropriate, harmful, or obscene content.
2. Cyberbullying, harassing, or threatening others via digital platforms.
3. Bypassing District security measures (e.g., using VPNs, proxies).
4. Plagiarizing or using generative AI without teacher permission.
5. Using District resources for non-school-related commercial or political purposes.
6. Unauthorized use of another individual's login credentials or accessing restricted files.

## 4. Privacy and Monitoring

- Student use of the DCS is not private. The District reserves the right to monitor all activity on the network and school-managed platforms.
- Data stored, accessed, or transmitted via District systems is subject to review for compliance and safety purposes.

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## 5. Consequences for Violations

Violations of the AUP may result in:

- Suspension or revocation of access to digital resources.
- Disciplinary action per the District's Code of Conduct.
- Legal action if appropriate, including restitution for damages.

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## 6. Digital Citizenship Education

- The District will provide instruction in responsible digital behavior, including internet safety, cybersecurity, data privacy, and media literacy.
- Staff are responsible for modeling appropriate digital conduct and guiding student use of technology.

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## 7. Parent/Guardian Responsibilities

Parents/guardians are encouraged to:

- Discuss the importance of digital safety and appropriate online behavior.
- Monitor their child's technology use at home.
- Support the District's efforts to maintain a safe and productive digital learning environment.

# Student Acceptable Use Policy (AUP) Acknowledgment Forms – Grades K-3 Students

## Grades K–3 | Classroom Use Only

***(No Student Signature Required)***

Students in grades K–3 use District-issued Chromebooks under direct teacher supervision during the school day. These students are not required to sign the AUP. Instead, they will receive age-appropriate instruction on safe, respectful, and responsible technology use. All use of the District Computer System (DCS) is governed by the Acceptable Use Policy.

## Parent/Guardian Acknowledgment (All Grades K–12)

I have reviewed the Middleburgh Central School District's Acceptable Use Policy and discussed it with my child. I understand the technology access provided at each grade level:

- Grades K–3: Supervised classroom Chromebook use only.

- Grades 4–6: Classroom use with occasional take-home access.

- Grades 7–12: Full-time access to an individually assigned Chromebook.

I support the District's expectations for safe, responsible technology use and understand that my child's activity on the District network may be monitored. I release the District, the Board of Education, and staff from liability related to any authorized use of District technology resources.

Parent/Guardian Name (printed): _____

Signature: _____

Date: _____

# Student Acceptable Use Policy (AUP) Acknowledgment Forms – Grades 4-6 Students

## Grades 4–6 | Classroom Use and Occasional Take-Home

I understand that:

- I use a Chromebook provided by the District during the school day and may occasionally take it home with permission.

- I will follow District rules and teacher instructions to use the Chromebook for school-related purposes only.

- Inappropriate use may result in restricted access or disciplinary consequences.

Student Name (printed): _____

Student Signature: _____

Grade: _____ Date: _____

## Parent/Guardian Acknowledgment (All Grades K–12)

I have reviewed the Middleburgh Central School District's Acceptable Use Policy and discussed it with my child. I understand the technology access provided at each grade level:

- Grades K–3: Supervised classroom Chromebook use only.

- Grades 4–6: Classroom use with occasional take-home access.

- Grades 7–12: Full-time access to an individually assigned Chromebook.

I support the District's expectations for safe, responsible technology use and understand that my child's activity on the District network may be monitored. I release the District, the Board of Education, and staff from liability related to any authorized use of District technology resources.

Parent/Guardian Name (printed): _____

Signature: _____

Date: _____

# Student Acceptable Use Policy (AUP) Acknowledgment Forms – Grades 7-12 Students

## Grades 7–12 | Assigned Chromebooks (1:1 Program)

I acknowledge that I have read and understand the District's Acceptable Use Policy. I agree to:

- Use my assigned Chromebook/laptop and access the DCS responsibly, both at school and at home.

- Care for the device and use it only for academic purposes.

- Comply with the Code of Conduct and all applicable rules.

- Accept the consequences for any misuse, including loss of access or disciplinary action.

Student Name (printed): _____

Student Signature: _____

Grade: _____ Date: _____

## Parent/Guardian Acknowledgment (All Grades K–12)

I have reviewed the Middleburgh Central School District's Acceptable Use Policy and discussed it with my child. I understand the technology access provided at each grade level:

- Grades K–3: Supervised classroom Chromebook use only.

- Grades 4–6: Classroom use with occasional take-home access.

- Grades 7–12: Full-time access to an individually assigned Chromebook/laptop.

I support the District's expectations for safe, responsible technology use and understand that my child's activity on the District network may be monitored. I release the District, the Board of Education, and staff from liability related to any authorized use of District technology resources.

Parent/Guardian Name (printed): _____

Signature: _____

Date: _____