BEACON CITY SCHOOL DISTRICT

Administrative Offices
10 Education Drive
Beacon, New York 12508
Phone: (845) 838-6900 * Fax: (845) 838-6905

REGISTRATION INSTRUCTIONS

Welcome to the Beacon City School District!

We are pleased to welcome you to the Beacon City School District. You will find all of our teachers, principals and other staff members helpful and eager to provide your child with the best possible education.

NYS law requires the District to enroll students who reside with their parent(s) or legal guardian (s) within our District. Only a parent or legal guardian may register a child. Students living within the District must provide proof of residency. Affidavit of legal guardianship or custody forms must be provided if the student is not living with the parent. All verifications are subject to District approval. **Only a parent or legal guardian may register a child.**

To register your child, please complete all forms attached and provide the documentation listed below to the Registrar at the Administration Office before registration can be finalized.

Proof Of Date of Birth – A birth certificate or record of baptism (domestic or foreign) with the original seal, passport (domestic or foreign) or visa. If those documents are not available, please provide one of the following:

Official driver's license
State or other government issued identification
School photo identification with date of birth
Consulate identification card
Hospital or health records
Military dependent identification card
Documents issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement)
Court orders or other court-issued documents
Native American tribal document; or
Records from non-profit international aid agencies and voluntary agencies

State law requires that the child's name, as it appears on the birth certificate, must appear on the office card, permanent record card, health card, transcripts, all diplomas and all other official records. Requests to use "nicknames" or other names on these records may not be honored.

☐ **Two (2) Proofs Of Residency – two of the following may be presented as accepted documentation**:

1. Proof of ownership of a house/condominium, such as a copy of a deed or mortgage statement
2. Copy of residential lease/rental agreement
3. Property or School Tax Bill
4. A sworn or unsworn statement by a third-party landlord, owner or tenant from whom the parent leases or shares property
5. Pay stub
6. Income tax forms
7. Utility, Insurance or other bills
8. Member documents based upon residency (e.g. Library card)
9. Voter registration documents
10. Official driver's license, learner's permit or non-driver ID
11. State or other government issued identification
12. Documents issued by Federal, State or Local agencies (e.g. Local Social Service agency, Federal Office of Refugee Resettlement)
13. Evidence of custody of the child

* If other documentation is provided, the Residency Officer will review the packet for registration permission

☐ **Student custody** - In case of divorce, separation, or legal guardianship, please provide court documents concerning custody of child signed by a judge (as well as any restraining orders currently in effect). If no such court documents exist, please request from the District and complete the affidavit of legal guardianship or Custody/Control forms.

☐ **Residency Questionnaire**

☐ **Proof Of Immunization / Physical Exam – According** to New York State Law and the District Policy, immunization records **MUST** be provided at time of registration. Also, New York State Education Law requires a Health Certificate to be furnished for each student upon entrance.

☐ **Report Card/Other School Records** – If the child is transferring from another school district, the last report card and/or previous school records **should** be provided.

☐ **IEP** –If the child has an IEP, a copy **MUST** be provided.

Signature of parent/guardian below will confirm that they have read and understand the residency policy of the Beacon City School District and the consequences they may incur if false information is provided. Furthermore, by signing below they attest that the information provided to the Beacon City School District, is true and accurate and any changes or residency (address, telephone, and guardianship) must be reported to the school registrar immediately. **Verification of residency may be requested at any time**.

Parent/Legal Guardian: ______________________________ Date: ______________

BEACON CITY SCHOOL DISTRICT
AFFIDAVIT OF RESIDENCY

Name(s) of Student's Parent(s)/Guardian(s)

State of New York SS: ____________________

County of Dutchess

____________________, being duly sworn, states and confirms:

Name(s) of Property Owner/Landlord/Property Officer

1. I am the owner or property officer for the owner of the property within the Beacon City School District, located at:

Street ____________________

P.O. Box ____________ Apt. ____________

City ____________ State ____________ Zip ____________

2. The below persons reside at the premises:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

To the best of my knowledge and information, the persons named above are residents of the described premises. I make the foregoing statements under the penalties for perjury and understand that determinations will be made based on the information I have given.

____________________ Signature of Landlord

____________________ Name of Landlord (Please print)

____________________ Address of Landlord

____________________ Phone Number of Landlord

Sworn before me

This ________ day of ____________ ________

____

Notary Public

Beacon City School District Student Registration Form

For Office Use ONLY	Student Id: ____________ Family Id: ________ Date of Entry: ________ School: ________
Today's Date: ________	Address Verified ☐ Birth Certificate ☐ Immunization Records ☐
☐New ☐Transfer ☐Re-enrolling	Grade at Entry: ______ *Note: Official grade level to be determined by Principal of assigned school.*

Check one: ☐ **Gr. 1-12** ☐ **Kindergarten** ☐ **Pre-K** ☐ **Pre-School**
☐ **IEP (Special Ed Dept.** ☐ **504 (General Ed)**

For Office Stamp

Please Print Clearly

Student Name: Legal Last Name	Legal First Name	Legal Middle Name

Birth Date (Mo./Day/Year) ____/____/______	Gender: ☐M ☐F	Birthplace: (City)__________ (State/Province)__________ (Country)__________

Ethnicity: (Check One)	**Primary Language Spoken by Child:**
Hispanic/Latino/Spanish Origin? ☐ Yes ☐ No	☐English ☐Other If other, please specify: __________
Race Code (Choose 1 or more) - Optional ☐ I-American Indian or Alaska Native	Primary Language Spoken by Parent/Guardian (other than English)
☐ A-Asian ☐ W-White	Mother: __________ Father: __________
☐ B-Black/African American ☐ P-Native Hawaiian /Other Pacific Islander	**Language Spoken in the Home**: __________

If you and your child are living in a shelter; with relatives or others due to lack of housing; in an abandoned apartment/building, in a motel/hotel, camping ground, car, train/bus station or other similar situation due to the lack of alternative, adequate housing; or temporarily housed in a shelter awaiting a OCFS permanent foster care placement you may be eligible for assistance with the enrollment process and transportation. If any of these housing situations apply, please check here ☐

Student's Address:

Residence Address	Street Apt # City State Zip
Mailing Address (if different from above)	Street Apt # PO Box City State Zip
Student resides with:	☐ Both Parents ☐ Parent One Only ☐ Parent Two Only ☐ Grandparents ☐ Guardian ☐ Foster Parents ☐ Step Parents ☐ Parent/Stepparent ☐ Self ☐ Other (Sepcify)______
Parent One	Last: Maiden: First:
Parent One's Residence Address	Street Apt # City State Zip
Mailing Address (if different from above)	Street Apt # PO Box City State Zip

Please check daytime phone *(used by principal, nurse, teacher, etc. for contact during the school day)*; include area code

☐ **Home Phone** ____-____-______ ☐ **Work Phone** ____-____-______ **ext.**_____ **Current Employer:** __________

☐ **Cell Phone** - - ☐ **Pager** - - **Email Address:**

Parent Two:	Last: First:
Parent Two's Residence Address	Street Apt # City State Zip
Mailing Address (if different from above)	Street Apt # PO Box City State Zip

Please check daytime phone *(used by principal, nurse, teacher, etc. for contact during the school day)*; include area code

☐ **Home Phone** ____-____-______ ☐ **Work Phone** ____-____-______ **ext.**_____ **Current Employer:** __________

☐ **Cell Phone** - - ☐ **Pager** - - **Email Address:**

Beacon City School District Student Registration Form

Step Parent - if applicable:	Last: First:
Step Parent's Residence Address	Street Apt # City State Zip
Mailing Address (if different from above)	Street Apt # PO Box City State Zip

Please check daytime phone *(used by principal, nurse, teacher, etc. for contact during the school day)*; include area code

☐ **Home Phone** _____-_____-_______ ☐ **Work Phone** _____-_____-_______ **ext.**_____ **Current Employer:** ____________________

☐ **Cell Phone** _____-_____-_______ ☐ **Pager** _____-_____-_______ **Email Address:** ____________________

Legal Guardian - if Applicable:	Last: First:
Guardian's Residence Address	Street Apt # City State Zip
Mailing Address (if different from above)	Street Apt # PO Box City State Zip

Please check daytime phone *(used by principal, nurse, teacher, etc. for contact during the school day)*; include area code

☐ **Home Phone** _____-_____-_______ ☐ **Work Phone** _____-_____-_______ **ext.**_____ **Current Employer:** ____________________

☐ **Cell Phone** _____-_____-_______ ☐ **Pager** _____-_____-_______ **Email Address:** ____________________

Please enter phone # for AUTOMATED CALLS *(used for school closings, district reminders, etc.)*; include area code: _____-______-________

Physical Custody with: ____

Is there a restraining order in effect? ☐ No

☐Yes (Legal papers must be on file with the District Registrar.
A copy will be sent to appropriate school enforcement.)

Restraining order is against: ☐Mother ☐Father ☐Other (please specify) ______________________________

Emergency Contacts: Please fill in information below for **at least two (2) contacts**

*** **DO NOT ENTER parent/guardian as an emergency contact** (as this information appears on page 1)

Contact 1 Last Name First Name	**Relationship**	**Phone # 1** (include area code) **Select one:** ☐Home ☐Work ☐Cell	**Phone # 2** (include area code) **Select one:** ☐Home ☐Work ☐Cell
________ ________	________	____-____-______	____-____-______
Contact 2 Last Name First Name	**Relationship**	**Phone # 1** (include area code) **Select one:** ☐Home ☐Work ☐Cell	**Phone # 2** (include area code) **Select one:** ☐Home ☐Work ☐Cell
________ ________	________	____-____-______	____-____-______
Contact 3 Last Name First Name	**Relationship**	**Phone # 1** (include area code) **Select one:** ☐Home ☐Work ☐Cell	**Phone # 2** (include area code) **Select one:** ☐Home ☐Work ☐Cell
________ ________	________	____-____-______	____-____-______

Beacon City School District Student Registration Form

Previous Schools Attended

Has Student attended Beacon City Schools before? ☐ Yes ☐ No

List all previous schools attended, including Beacon City School District **(list most recent first)**

School Name	Address	City	State	From	To	Grade(s)	Please Check:	
							☐Public	☐Private
							☐Public	☐Private
							☐Public	☐Private
							☐Public	☐Private
							☐Public	☐Private
							☐Public	☐Private

Year began school in the United States: ____________

Special Services

Has your child ever qualified for or been enrolled in a Special Ed. Program? ☐ Yes ☐ No

Has your child ever qualified for or had a 504 plan? ☐ Yes ☐ No

Has your child ever participated in:
☐ Title ☐ IEP ☐ Gifted ☐ Speech ☐ Other ____________________

Has your child ever been enrolled in English as a Second Language Program? ☐ Yes ☐ No

Has your child been retained? ☐ Yes ☐ No

If yes, what grade? _______

NOTE: Official grade level will be determined by the Principal of the assigned school.

Safety

Has your child ever been suspended for a weapons violation? ☐ Yes ☐ No If Yes, date: _____________

Siblings: Please list siblings attending the Beacon City School District:

Last Name	First Name	School	Grade

Student Release Authorization

Legal Parent Signature: ____ **Date:** ____________________

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background

(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other ________ *specify*	
2. What was the first language your child learned?	☐ English	☐ Other ________ *specify*	
3. What is the Home Language of each parent/guardian?	☐ Mother ________ *specify*	☐ Father ________ *specify*	
	☐ Guardian(s) ________ *specify*		
4. What language(s) does your child understand?	☐ English	☐ Other ________ *specify*	
5. What language(s) does your child speak?	☐ English	☐ Other ________ *specify*	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other ________ *specify*	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other ________ *specify*	☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school ____________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ *If yes, please explain:____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ **No** ❑ **Yes*** *Please complete 10b below

10b. ***If referred for an evaluation,*** **has your child ever *received* any special education services in the past?**
❑ No ❑ Yes – Type of services received:____

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? ____________________________

____ Month: Day: Year: ____________

Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ **Mother** ❑ **Father** ❑ **Other:**____________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ______________________ **POSITION:** ______________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: ______________________ **POSITION:** ______________________

ORAL INTERVIEW NECESSARY: ❑ **NO** ❑ **YES**

****DATE OF INDIVIDUAL INTERVIEW:** ____________ MO DAY YR.

OUTCOME OF INDIVIDUAL INTERVIEW: ❑ ADMINISTER NYSITELL ❑ ENGLISH PROFICIENT ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: ______________________ **POSITION:** ______________________

DATE OF NYSITELL ADMINISTRATION: ____________ MO. DAY YR.

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

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

OBE-WL

Office of Bilingual Education and World Languages

Bilingual Education

Home Language Questionnaires

- Link to NYS ELL Identification Process (51 KB)

English	Albanian	Amharic
Arabic	Bengali	Bulgarian
Burmese	Chinese Simplified	Chinese Traditional
French	Fulani	German
Haitian Creole	Hausa	Hebrew
Hindi	Hmong	Igbo
Italian	Japanese	Karen
Korean	Marshallese	Maay Maay
Nepali	Polish	Portuguese
Punjabi	Romanian	Russian
Somali	Spanish	Swahili
Tibetan	Ukrainian	Urdu
Uzbek	Vietnamese	Yiddish
Yoruba	Zulu	

Dr. Matthew Landahl
Superintendent of Schools

BEACON CITY SCHOOL DISTRICT
ADMINISTRATIVE OFFICES
10 Education Drive
Beacon, New York 12508
845-838-6900 phone

Mrs. Ann Marie Quartironi
Deputy Superintendent

Mrs. Cecilia Dansereau-Rumley
Assistant Superintendent for Instructional Services

Mr. Erik Wright
Executive Director of Curriculum and Instruction

Mrs. Dawn Condello
Director of Pupil Personnel Services

Mr. John Giametta
Director of Physical Education, Athletics, Health, and Recreation

Dear Parent/Guardian,

The Beacon City School District nursing staff would like to welcome your child to our district. In order to provide the best possible care to your child, a health record needs to be created (or updated if your child is re-entering the district). In order to do this, please include the following documentation with your registration packet.

1) A complete immunization record.
2) The enclosed health certificate (physical examination) which needs to have been completed within the last 12 months. If you cannot provide this, please sign the enclosed consent form for a physical examination to be performed by the school healthcare practitioner at school.
3) The enclosed health history form.
4) The enclosed authorization form to share medical information with school staff as needed.

If you have any questions or if your child has specific medical needs, please contact your child's school nurse. The forms above, as well as the contact information for all of our school nurses, can be found on the BCSD website, under Departments – Health Services.

Thank you,

Laura Seaman, RN

Laura Seaman, RN, BSN, BFA
BCSD Nurse Manager
Email: seaman.l@beaconk12.org
Phone: (845) 838-6900, ext. 3229
Fax: (845) 838-0796

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type	☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ______________
Seizures ☐ No	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type	☐ Type: ______________ Date of last seizure: __________
Diabetes ☐ No	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type	☐ Type 1 ☐ Type 2 ☐ HbA1c results: __________ Date Drawn: __________

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: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	**Positive**	**Negative**	**Date**	**Other Pertinent Medical Concerns**
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: __________
Lead Level Required Grades Pre- K & K			**Date**	☐ Mental Health: __________
☐ Test Done	☐ Lead Elevated ≥10 µg/dL			☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)	ICD-10 Code
__________	__________
__________	__________
__________	__________
__________	__________

☐ Additional Information Attached

Dr. Matthew Landahl
Superintendent of Schools

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Dear Parent/Guardian:

New York State Education Department requires a physical exam for each student upon entrance to school and for students in Grades Pre-K or K, 1, 3, 5, 7, 9, and 11; annually for interscholastic sports; working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

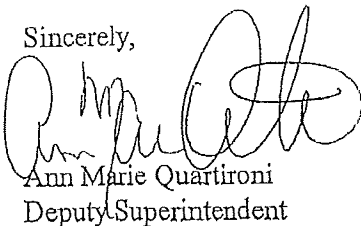
Options for Completion:

1) Since your private health care provider has a more complete understanding of your child's health, we respectfully urge that you take your child to him/her for the physical examination. Please have the attached Health Examination Form filled out and return it to your child's school nurse's office. **Please be advised that a physical examination is only valid for one year from the month it was performed.**

2) If you want to have the required physical examination conducted by the school health care practitioner (free of charge), you must sign in the consent box below and return it to your child's school nurse. Upon receipt of your consent, the physical examination will be scheduled for the next available appointment. You will only be notified following the examination if there are any findings that are not within normal limits.

If you have any questions, please call your child's school nurse.

Sincerely,



Ann Marie Quartironi
Deputy Superintendent

PARENT/GUARDIAN CONSENT

You must sign here to give consent for the school health care practitioner to perform a physical examination on your child during the current school year.

Student's Name:____________________

Grade:__________ Date of Birth:__________

Parent/Guardian Name:____________________

Parent/Guardian Signature:____________________

Date:__________

May 2018

Beacon City School District
Beacon, NY 12508

HEALTH HISTORY FORM

(To be completed by the Parent/Guardian)

Student's Name:_________________________________ DOB:___________ ☐M ☐F Grade:____

Has your child ever had:	NO	YES	Explain "Yes" answers
Allergies (food, insect, medication, other)			☐ Epi-Pen ☐ Benadryl
Arthritis			
Anemia (or sickle cell disease)			
Asthma (or other respiratory conditions)			☐ Inhaler ☐ Nebulizer
Back or Neck Conditions			
Bladder or Kidney Conditions (or only one kidney)			
Convulsions/Seizures/Epilepsy			
Dental Conditions (orthodontics, caps, bridge, mouthpiece)			
Diabetes			
Ear Conditions (or hearing loss)			
Eye Conditions (or uncorrectable loss of vision in one or both eyes)			☐ Contacts ☐ Glasses
Fainting Episodes			
GI Conditions (stomach ulcer, IBS, reflux)			
Headaches/Migraines			
Head Injury (or concussion)			
Heart Conditions (murmur/chest pain/high blood pressure)			
Hernia (or Hernia Repair)			
Joint Injuries or Pain Specify left or right AND which joint was affected			
Mental Health Conditions			
Nose Fracture or Frequent/Severe Bleeds			
Physical limitations related to Physical Education or Sports			
Surgery or been hospitalized overnight			
Only one functional testicle			
Illness or injury, lasting more than 5 days, since his/her last physical exam?			
Does your child take any medication daily?			
Is there anything else the school nurse should know about your child?			
Child's Doctor (name)			Phone #
Child's Dentist (name)			Phone #

Parent (Guardian) Print Name

Parent (Guardian) Signature

Date

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Superintendent of Schools

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Authorization for Use or Disclosure of Protected Medical Information

Student's Name:______________________________________Date Of Birth:____________

I am the legal parent/guardian of the above named student and do hereby give permission to the Beacon City School District nurse's offices to release pertinent medical information from my child's school health record to school personnel as needed. Any information which is shared will be for the purpose of ensuring the safest possible environment for your child and will help to meet their medical/educational needs while they attend school in the Beacon City School District.

This authorization shall be enforced and in effect from the date signed below until my child graduates and/or is discharged from the Beacon City School District, at which time this authorization to use or disclose this protected medical information will expire.

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Beacon City School District nurse's office where my child is a student. I understand that the revocation of this authorization is not effective if the Beacon City School District nurse's office has used this authorization for disclosure of the protected medical information before receiving my written notification.

I understand that any protected medical information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that my child's treatment is not dependent on my agreement to release or withhold information.

APPROVAL (Parent/Guardian's Signature)____

Parent/Guardian's Name (Printed) ______________________________Date ____________

Revised 2/18

BEACON CITY SCHOOL DISTRICT

Administrative Offices

10 Education Drive

Beacon, New York 12508

Phone 845-838-6900

Pupil Personnel Services FAX 845-838-6933

Dear Parent/ Guardian of ______________________:

This is to ask your permission (consent) to bill Medicaid for Medicaid reimbursable services that are on your child's individualized education program (IEP). Schools in New York State routinely access Medicaid funding to help meet costs of providing special education services. Please read and confirm the following information:

I, ____ as the parent/guardian of

____,

(Print child's name)

give permission for the school district/municipality to use Medicaid to pay for special education services rendered on behalf of my child for all Medicaid eligible services listed on my child's IEP dated: ____________________________________.

I understand that the use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for other services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program and that I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's entitlement to a free appropriate public education (FAPE) is in no way dependent on my granting consent and that, regardless of my decision to provide this consent; all the required services on my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: ______________________ Date: ______________

BEACON CITY SCHOOL DISTRICT

BEACON, NEW YORK 12508

TRANSPORTATION REQUEST

Check Appropriate Box:

☐ New Entrant ☐ Change Of Address ☐ Displacement ☐ Transfer ☐ Medical 504

Students Must Reside 1.5 Miles or More From The School They Attend To Receive Bussing.

SCHOOL: ______________________________ **SCHOOL YEAR:** ____________________

Enter Grade (1-12): _________ or check one: **K** _____ **PRE-K A.M.** _____ **PRE-K P.M.** _____

Student's Name: ______________________________ **Date of Birth** ______________

Student's Address: ____
Address City State Zip Code

Mailing Address: ____
(If Different) Address/PO Box City State Zip Code

Parent's Name: ______________________________

Home Phone # ____________ **Work Phone #** ____________ **Cell Phone #** ____________

Emergency Contact: __________________ **Phone # of Emergency Contact** __________ **(Other Than Parent)**

Special Transportation Request

Daycare, Child Care, Displacement

Students in Pre-K through 8th Grade are eligible for Day Care/Child Care.

____
Name of Day Care Center, Child Care Provider or Housing Site

____ ____________________
Address of Day Care Center, Child Care Provider or Housing Location Phone Number

Pick Up Location In A.M.: ☐ Day Care/Child Care Provider/Housing Site ☐ Home ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ All

Drop Off Location In P.M.: ☐ Day Care/Child Care Provider/Housing Site ☐ Home ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ All

________________________________ ______________
Parent's Signature Date

For Office Use Only

To School Route: ____________ *From School Route:* ____________

BEACON CITY SCHOOL DISTRICT

ADMINISTRATIVE OFFICES
10 EDUCATION DRIVE
BEACON, NEW YORK 12508
PHONE 845-838-6900
FAX 845-838-6905

DR. MATTHEW LANDAHL
Superintendent of Schools

MRS. ANN MARIE QUARITONI
Deputy Superintendent

MRS. CECILIA DANSEREAU-RUMLEY
Assistant Superintendent of Human Resources & Accountability Systems

MR. ERIK WRIGHT
Assistant Superintendent of Curriculum & Student Support

MRS. DAWN CONDELLO
Director of Pupil Personnel Services

MR. JOHN GIAMETTA
Director of Physical Education, Health Services, Athletics, and Recreation

ENROLLMENT FORM-RESIDENCY QUESTIONNAIRE

Name of LRE: Beacon City School District

Student Last Name:________________________ First Name:____________________ M.I:______

Gender: ☐ Male ☐ Female Date of Birth: ___/___/___ Current Grade:______
Month Day Year (Preschool -12)

Address:____ Phone:_________________________

City:________________________________ Zip Code:____________________

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 transportation and other services.

Where is the student currently living? (*Please check **one** box)*

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred as "double up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campus
- ☐ Other temporary living situation (please describe)____________________________________
- ☐ In permanent housing

____

Print name of Parent/Guardian **OR** student if Unaccompanied Homeless youth

____

Signature name of Parent/Guardian **OR** student if Unaccompanied Homeless youth

____

Date

For Office Use Only
Circle One: New to District Re-Entry New Address Change of Guardian
School (check one) ☐ South ☐ Sargent ☐ JVF ☐ GLN ☐ RMS ☐ BHS
☐ Private School:____________________

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FORMULARIO DE INSCRIPCIÓN - CUESTIONARIO DE VIVIENDA

Nombre de LRE: Beacon City School District

Estudiante: Apellido:________________________ Primer Nombre:___________________ Inicial:______

Género: ☐ Masculino ☐ Femenino Fecha de nacimiento: ___/___/___ Grado:_________
Mes Dia Año (Pre-escolar -12)

Direción:_______________________________________ Teléfono:_________________________

Ciudad:_________________________________ Código Postal:___________________

La respuesta que ud. provea debajo ayudará al distrito a determinar qué servicios usted o su niño/a podrían recibir bajo el Acto McKinney-Vento. Los estudiantes que están protegidos bajo el Acto McKinney-Vento tienen derecho a inscripción inmediata en la escuela incluso si no tienen los documentos requeridos normalmente, como prueba de residencia, récords escolares, récords de vacunas, o certificado de nacimiento. Los estudiantes que están protegidos bajo el Acto MCKinney-Vento podrían también tener derecho a transportación y otros servicios.

¿Dónde vive el estudiante actualmente? (*Por favor marque una opción solamente*)

- ☐ En un refugio
- ☐ Con otra familia u otra persona debido a pérdida de residencia o como resultado de dificultad económica (referido a veces como *double up*)
- ☐ En un hotel/motel
- ☐ En un auto, parque, bus, tren o campus
- ☐ Otro tipo de situación de vivienda (por favor describa)____________________________________
- ☐ En una vivienda permanente

____

En letra de molde Nombre de Padre/Guardián **O** de estudiante si es un Menor Sin Hogar No Acompañado

____

Firma Nombre de Padre/Guardián **O** de estudiante si es un Menor Sin Hogar No Acompañado

____

Fecha

Para uso de oficina solamente - *For office use only*

Circle One: New to District Re-Entry New Address Change of Guardian

School (check one) ☐ South ☐ Sargent ☐ JVF ☐ GLN ☐ RMS ☐ BHS

☐ Private School:___________________

Beacon City School Districtrict
Committee on Special Education
10 Education Drive
Beacon, New York 12508
<u>Medicaid Consent</u>

Date:______________

Student Name:
DOB:
Does student have a Client Identification Number (CIN): Yes ☐ CIN number:________ ☐No

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP).

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

I, ______________________________as the parent/guardian of «Student FirstName ______________________________» StudentLast Name» ______________________________,
have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

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

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

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

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

Parent/Guardian Signature: ______________________________

Print Name: ______________________________ Date: ______________

OFFICE USE ONLY:

Form must be submitted to Mrs. DiCastro upon completion of form. If student has CIN number please make copy of CIN card and attach to the form.

Beacon City School District
Committee on Special Education
10 Education Drive
Beacon, New York 12508
Medicaid Consent

Fecha: _______________

Nombre de estudiante:
Fecha de nacimiento:
El estudiante tiene un Número de Identificación de Cliente (CIN): ☐ Si, no. CIN:_______ ☐ No

Este formulario es para pedir su permiso (consentimiento) de facturar al Programa de Seguro de Medicaid suyo y de su niño/a por educación especial y servicios relacionados que están en el Programa de Educación Individualizado (IEP).

Este consentimiento le permite al distrito de escuela a facturar por los servicios relacionados a la salud cubiertos y a divulgar información al Agente de Facturación de Medicaid del distrito de escuela para este propósito.

Yo,_______________________________________ como el padre/guardián de **(primer nombre del estudiante)**___________________________**(apellido del estudiante)** ___________________________, he recibido una notificación escrita del distrito de escuela que explica mis derechos federales sobre el uso de beneficios públicos o seguro a pagar por cierta educación especial y servicios relacionados.

Comprendo y acepto que el distrito de escuela pueda accesar Medicaid para pagar por educación especial y servicios relacionados provistos a mi niño/a.

Comprendo que:

- Proveer consentimiento no imparctará la cubierta de Medicaid mía o de mi niño/a;
- Al ser solicitados, yo puedo revisar copias de los récords divulgados conforme a esta autorización;
- Los servicios listados en el IEP de mi niño/a deben ser provistos sin costo adicional a mi independientemente de yo dar mi consentimiento o no a facturar a Medicaid;
- Tengo el derecho de retirar consentimiento en cualquier momento; y
- El distrito de escuela debe proveerme notificación anual escrita de mis derechos sobre este consentimiento.

También doy consentimiento al distrito de escuela a divulgar los siguientes récords/información sobre mi niño/a a la Agencia de Medicaid del Estado para facturar por educación especial y servicios relacionados que están en el IEP de mi niño/a. Los siguientes récords serán compartidos:

Récords a ser compartidos/divulgados (tal y como récords o información sobre los servicios que el menor recibe)	
IEP	Reporte de administración de medicamentos
Referido/orden escrita	Registro de transportación especial
Reportes de evaluación	Otra información de identificación personal
Notas de sesiones	Cualquier otra información específica relacionada a los servicios programa del estudiante

Doy mi consentimiento voluntariamente y entiendo que puedo retirar mi consentimiento en cualquier momento. También entiendo que el derecho de mi niño/a a recibir educación especial y servicios relacionados no es dependiente de ninguna manera a mi acción de dar consentimiento y que, independientemente de mi decisión de dar este consentimiento, todos los servicios requeridos en el IEP de mi niño/a serán provistos a él/ella sin costo alguno

Firma de Padre/Guardián: ______________________________

Nombre en letra de molde: ______________________________ Fecha: ________________________

OFFICE USE ONLY (*PARA USO DE OFICINA SOLAMENTE*):

Form must be submitted to Mrs. DiCastro upon completion of form. If student has CIN number please make a copy of CIN card and attach to the form.

BEACON CITY SCHOOL DISTRICT
ADMINISTRATIVE OFFICES
10 Education Drive
Beacon, New York 12508
845-838-6900 phone
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Parental Rights to referral and Evaluation for Special Education Services or Programs

The Beacon City School District offers supports for students in general education as psychological services, curriculum and instructional modifications and Academic Intervention Services (AIS). The Response to Intervention (RtI) team in your child's school may make a referral to the Committee on Special Education (CSE) if documented interventions have been implemented/monitored are to be found not successful. In addition, parents and guardians have the right to refer their child to the Committee on Special Education (CSE).

A referral is a written statement asking that the school district evaluate your child to determine if he or she needs special education services. This written statement should be addressed to:

Dawn Condello
Director of Pupil Personnel Services
10 Education Drive
Beacon, NY 12508

There is a requirement that the building principal offer to meet with you to discuss other ways to help your child. As a result, you may withdraw your referral or ask that the referral process continue.

Additional information is available in English and Spanish in a document called, *A Parent's Guide to Special Education at* www.nysed.gov.

BEACON CITY SCHOOL DISTRICT
ADMINISTRATIVE OFFICES
10 EDUCATION DRIVE
BEACON, NEW YORK 12508
PHONE: (845) 838-6900 x 2002
REGISTAR'S FAX: (845) 231-0479

RELEASE OF STUDENT INFORMATION

Please fill out the information below:

Student's Name: ______________________________ Date of Birth: ____________________

Previous Address: ____

City: ____________________ State: _______________ Zip Code: ________________

Printed Name of Parent/Guardian: ____

Name of Former School/Organization: ____

Address: ____

City: ____________________ State: _______________ Zip Code: ________________

Phone Number: ( ) __________________ Fax Number: ( ) __________________

I hereby authorize my child's former school district (listed above) to forward all the information listed as applicable to:

Mrs. Gail Morgan, Registrar
Beacon City School District
10 Education Drive
Beacon, New York 12508
Fax: (845) 231-0479

☐ **Academic Records**
☐ **Psychological Evaluations**
☐ **Medical & Immunization**
☐ **Discipline Records**
☐ **Social History**
☐ **Test Scores**
☐ **IEP Plans**

It is my understanding that these records are for the school district use ONLY.

______________________________ ______________________________
Signature of Parent/Guardian Date