WHITNEY POINT CENTRAL SCHOOL DISTRICT

P.O. BOX 249 • WHITNEY POINT, NY • 13862
PHONE: 607.692.8202 • FAX: 607.692.4434

STUDENT REGISTRATION FORM

Office Use Only

Date of Entry ______________
ID Number ______________
Grade (Team) ______________
Homeroom Number ______________
Teacher ______________
Pin # ________ Locker # ________
Bus Route Number ______________
COHORT (grade 9 entry) ______________

Today's Date ______________

Student's Name ______________________________
First Middle Last

Phone Number ______________

Mailing Address ______________

____

Date of Birth ______________

Gender: M / F ________

Physical Address ______________

____

Place of Birth City ______________State________

Grade ________ Grades Repeated ________

Directions to home from school______________________________

____

Previous school attended ______________

Address ______________

____

Previous school counselor ______________

Has student ever attended any Whitney Point school? ______________

If yes, what school(s)? ______________

If yes, what grade(s)? ______________

Parent / Guardian Contact Information (with whom student resides)

#1 Name ______________________________
First Middle Last

Relationship: ☐ Father ☐ Mother
☐ Other (please specify)____________

Phone Number (home)______________

Phone Number (cell) ______________

Employed by ______________

Work Phone Number ______________

Address ______________

E-mail address ______________

Education: ☐ 12th grade or less, no diploma ☐ High School Grad
☐ Some college, no degree ☐ Associate Degree
☐ Bachelor Degree or higher

#2 Name ______________________________
First Middle Last

Relationship: ☐ Father ☐ Mother
☐ Other (please specify)____________

Phone Number (home)______________

Phone Number (cell) ______________

Employed by ______________

Work Phone Number ______________

Address ______________

E-mail address ______________

Education: ☐ 12th grade or less, no diploma ☐ High School Grad
☐Some college, no degree ☐ Associate Degree
☐ Bachelor Degree or higher

(Please turn form over to continue)

Parents' Names: Father ______________________________

Mother ______________________________ (maiden) ____________

Are parents separated? ______If yes, child is living with: ______________________________
Name Relationship to child

If there is joint or sole custody or any other court order for child/children, please supply necessary proof.

Office Use Only	
Court Order on File (yes/no) ________	Date ______________

Name(s) of people currently living in household with student (**please include siblings in other buildings**):

First Name	**Last Name**	Relationship to Child	Work Phone *or* DOB/School/Grade

How **long** have you lived at your current residence? ______________________________

Emergency Contact Information

Emergency Contact 1 (Note: This person will be contacted **FIRST**)

Name ______________________________
First Middle Last

Phone Number ____________________ Employed by ____________________

Contact 1 Address ____________________ Work Phone Number ____________________

____________________ Relationship to Child ____________________

Emergency Contact 2

Name ______________________________
First Middle Last

Phone Number ____________________ Employed by ____________________

Contact 2 Address ____________________ Work Phone Number ____________________

____________________ Relationship to Child ____________________

Was student receiving free or reduced lunch/breakfast at previous school? ________ If yes, was receiving ________ free ________ reduced

Does student have an **IEP**, **504** or any special needs? ______________________________

Additional Comments: ______________________________

Parent/GuardianSignature ______________________________ **Date** ____________
(required)

STUDENT RACIAL AND ETHNIC IDENTIFICATION

STUDENT NAME: Last, First, Middle: ______________________________ Grade Level: __________

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ **YES, Hispanic**
☐ **NO, not Hispanic**

2. Select one or more races from the following five racial groups [For question (2) Check (√) all groups that apply to your child; check (√) **at least** ONE box.]:

☐ **BLACK OR AFRICAN AMERICAN**: A person having origins in any of the Black racial groups of Africa.

☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **ASIAN**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

*Is Student an IMMIGRANT to US? ________________ IF Yes: Date of Entry / Years into US ________________________

*Primary Language Spoken in the Home (required) ________________________ Country of Origin ____________________

______________________________ ____________________
Signature of Parent/Guardian/Other Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify)______________________

STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: The *WHITNEY POINT SCHOOL DISTRICT* is required to collect and record the ethnic identity of students in the *WHITNEY POINT SCHOOL DISTRICT* in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the top of this page. Put a check (√) in the box for the category or categories which best describe your child. The *WHITNEY POINT SCHOOL DISTRICT* understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.
The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

WHITNEY POINT CENTRAL SCHOOL DISTRICT
Caryl E. Adams School
PO Box 249, Whitney Point, NY 13862 Phone: 607-692-8238 Fax: 607-692-8297

New Student Health Profile

Child's Name ____
First Middle Last

Physician's Name ____________________ Phone Number ________________

Significant Health Information: Give dates and explain. If it does not apply please write N/A.

Asthma ______________________ Hepatitis ______________________

Birth Defect ______________________ Mononucleosis ______________________

Bone, Joint Problems ______________________ Pneumonia ______________________

Muscular Problems ______________________ Chicken Pox ______________________

Seizure Disorder ______________________ Diabetes ______________________

Speech Problem ______________________ Frequent Colds ______________________

Tuberculosis Contact ______________________ Frequent Ear Infections ______________________

Whooping Cough ______________________ Heart Disease ______________________

Other ____

Serious Injuries: ______________________ Date: ______________

Operations:

Appendectomy: ______________ Date: ______________
Tonsillectomy: ______________ Date: ______________
Other: ______________

Current Medications: ____

Allergies: Please specify type of reaction and what treatment is needed.

Bee Sting ____

Foods ____

Environmental ____

Medication ____

Other ____

Does your student have eye problems: No ____ Yes (explain below) ____

Glasses ______ Contact Lenses ______ Correction ______

Eye Doctor's Name ______________________________

Does your student have hearing difficulties: No ____ Yes (please explain) ___

Explain ______________________________

Ear tubes ______________ Preferential seating ______________

Ear Doctor's Name ______________________________

NY STATE Immunization Requirements:

Proof of the following immunizations is required to attend school in New York State:

3 doses of diphtheria toxoid (administered as either DTP, DTaP, DT or TD)
3 doses of OPV, or 4 doses of IPV
2 doses of live measles vaccine for children born after 01/01/85
1 dose of live mumps vaccine
1 dose of live rubella vaccine
3 doses of hepatitis B vaccine: Children born after 01/01/93 must have completed this series for kindergarten entry.

Parent's Signature ______________________________ **Date** __________

RESIDENCY QUESTIONNAIRE – ENROLLMENT FORM

Name of LEA: Whitney Point Central School District

Name of School: ____________________

Name of Student: ____________________
Last First Middle

Gender: ☐ Male ☐ Female
Date of Birth: _____ / _____ / _____ (*Month* *Day* *Year*)
Grade: __________ *(preschool-12)*

Address: ____________________ Phone: __________

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

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

☐ In permanent housing

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

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

____
Date

If the student is NOT living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

NOTE TO SCHOOL / LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form (STAC 202) is completed.

Whitney Point Central School District

Caryl E. Adams Primary School

P.O. Box 249, Whitney Point, NY 13862

Phone: 607-692-8241 Fax: 607-692-8297

Jo-Anne Knapp, Principal

To Whom It May Concern:

The following student(s) have registered in our school district today:

Name: Grade: DOB:

Please send any and all academic/health records you may have for this student to:

Caryl E. Adams School
P.O. Box 249
Whitney Point, NY 13862
Fax: (607) 692-8297

Please send all Committee on Special Education and/or psychological records to:

Chairperson, Committee on Special Education
Whitney Point Central School
P.O. Box 249
Whitney Point, NY 13862

Thank you for your expedience in forwarding this student's records.

Sincerely,

Jo-Anne Knapp
Principal

* *

I hereby authorize the release of all scholastic, health, psychological, and attendance records and any other pertinent information concerning the above named student to the Caryl E. Adams School.

______________________ Signature

______________________ Relationship

______________________ Date

The Mission of the Whitney Point Central School District is to provide an excellent education ensuring that all children maximize their potential, become contributing citizens, and pursue lifelong learning.

C. E. ADAMS SCHOOL
Whitney Point Central Schools

Dear Parents:

During the school year, the children take several excursions and field trips. These are under the supervision of teachers with the aid of a parent.

It is necessary for us to have a signed permission slip from you granting permission for your child to attend these trips. Please return this slip with your signature as soon as possible.

Thank you.

Sincerely,

Jo-Anne Knapp
Principal

Student's Name ________________________________ Grade ________

Date ________________ Signature ________________________________

Dear Parent:

The Whitney Point Central School District, in cooperation with the New York State Department of Health and the New York State Department of Education is offering the elementary school students a supplemental fluoride mouthrinsing program to prevent dental decay.

This simple method of applying fluoride is safe and effective in controlling tooth decay, and requires only a few minutes of classroom time. Participants will rinse their mouths in school under **direct supervision** with a 0.2% neutral sodium fluoride solution for one minute once a week. The ingredients in the clear pre-mixed, individual fluoride mouthrinse unit dose are sodium fluoride, potassium sorbate, saccharin sodium, citric acid and purified water. These ingredients are also common to toothpaste and other over-the-counter dental care products. This is a rinse and spit procedure and therefore not intended for swallowing.

Studies show that a weekly fluoride mouthrinsing reduces tooth decay. We encourage you to allow your child to participate in this valuable preventive program. Your child's participation is entirely voluntary and you may withdraw your child from the program at any time. For the current school year, the program will be completely funded by the New York State Department of Health, Bureau of Dental Health and your child may participate at NO COST. This Supplemental Fluoride Rinsing and Education Program is, however, in no way a substitute for routine dental care. Your child must continue proper home care habits and routine dental checkups. Please read and return the completed form without delay to your child's teacher.

Sincerely,

Superintendent

= =

PARENTAL PERMISSION FORM

Self-Applied Fluoride Education and Rinsing Program (SAFER)

____ I give permission for my child to participate in the Supplemental Fluoride Mouthrinse Program.

____ I do not want my child to participate in the Supplemental Fluoride Mouthrinse Program.

____ Our drinking water is fluoridated.

Parent/Guardian Signature: ____

Address: ____

____

Phone Number: ____________________ **Teacher:** ____________________

Child's Name: ______________________________ **Grade:** ______

School Name: ____

PLEASE COMPLETE AND RETURN BY ______________. YOUR PROMPT RESPONSE IS APPRECIATED.
(Form Updated 02/06)