HERMON-DEKALB CENTRAL SCHOOL
709 EAST DEKALB ROAD
DEKALB JUNCTION, NEW YORK 13630
PHONES: 315-347-3442 or 315-347-3548
FAX: 315-347-3817

I HEREBY AUTHORIZE (Previous School):

_____ Phone Number: _____
Name of School

_____ Fax Number: _____
Mailing Address

_____
City/State/Zip Code

TO RELEASE/RECEIVE ALL CONFIDENTIAL INFORMATION FROM THE RECORDS OF:

STUDENT'S NAME	**BIRTHDATE**	**GRADE LEVEL**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TO/FROM:

Hermon-DeKalb Central School
Attn: Angie Fenlong (afenlong@hdcsk12.org) Pre-K - 6
Attn: Kate Harmer (kharmer@hdcsk12.org) 7-12
709 East DeKalb Road
DeKalb Junction, New York 13630

THIS CONFIDENTIAL INFORMATION INCLUDES:

* ACADEMIC INFORMATION
* HEALTH AND ATTENDANCE RECORDS
* COMMITTEE ON SPECIAL EDUCATION/PSYCHOLOGICAL RECORDS
* ACADEMIC INTERVENTION SERVICES (AIS)/RESPONSE TO INTERVENTION (RtI)
* BIRTH CERTIFICATE
* STANDARDIZED/STATE TEST SCORES
* CUSTODY INFORMATION

I am the Parent _____ Legal Guardian _____ D.S.S. Caseworker _____ of the above student(s).

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**

IN ACCORDANCE WITH PUBLIC LAW 93-380 "FAMILY EDUCATION RIGHT AND PRIVACY ACT OF 1974, "THIS IS AUTHORIZATION TO RELEASE A COPY OF STUDENT RECORDS (INCLUDING COMPLETE TRANSCRIPT OF THE SCHOOL RECORD, STANDARDIZED TEST RESULTS, HEALTH RECORDS AND PSYCHOLOGICAL REPORTS.) Revised: 12/09/10

For Office Use Only

REGISTRATION & HEALTH INFORMATION FORM

I.D. NUMBER _____
ENTRY DATE _____

HERMON-DEKALB CENTRAL SCHOOL
DEKALB JUNCTION, NEW YORK 13630

GRADE _____ BUS # (IN) _____
HOMEROOM # _____ BUS # (OUT) _____

Name of Pupil _____ D.O.B. ___/___/___ Birth Place _____ Sex: M F
Last First Middle Mo Day Year City State

Home Address (911 Address) _____
Road or Street Name Town State Zip

Mailing Address (*if different*) _____
P O Box Number Town State Zip

☐ Check here if you reside in a temporary home that you do **NOT** own, lease, rent, or sublet *(shelter, with relatives or others, abandoned apartment/building, motel/hotel, camping ground, car, train/bus station).*

Home Phone _____ Cell Phone _____ Work Phone _____ Email Address _____

Transferred From: _____
School Name Town State Zip

Previous 911 address: _____

Has the above student ever attended Hermon-DeKalb Central in the past? _____ If so, when? _____ **CSE Services:** Yes or No

Ethnic Origin: [ ] Asian - [ ] American Indian/Alaskan Native – [ ] Black – [ ] Hispanic – [ ] Pacific-Islander - [ ] White

Home Language (Language Spoken in the Home if Not English) _____

Father or Male Guardian _____
Last First Middle (Relationship to Child)

Mother or Female Guardian _____
Last First Middle (Relationship to Child)

Additional Adult(s) in Household _____
Last First (Relationship to Child)

Who is the Custodial Parent? _____ Are there any legal custody arrangements? _____
****PLEASE SUBMIT A COPY OF THE CUSTODY AGREEMENT. THE SCHOOL IS BOUND BY LAW TO ADHERE TO THIS DOCUMENT.**

Non-Custodial Parent _____ Address _____

Should the non-custodial parent receive school mailings? _____ May the non-custodial parent pick the child up from school? _____

Copies (10) to: Beaulieu, Brice, Clemons, Fetcie, Fenlong, Foster, Germano, Morrill, Reed, Homeroom Teacher

Siblings or Other Children in the Household:

Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)
Last	First	Middle	Birthdate	(Relationship to Child)

Emergency Information
(Please fill out any applicable information)

Guardian Work Information: _____
Name Place of Employment Phone Number

Guardian Work Information: _____
Name Place of Employment Phone Number

Other Emergency Contact: _____
Contact Name (Relationship to Child) Phone Number

Other Emergency Contact: _____
Contact Name (Relationship to Child) Phone Number

HEALTH DATA: A COPY OF BIRTH CERTIFICATE AND IMMUNIZATIONS REQUIRED AT TIME OF REGISTRATION

Child's Doctor_____ Child's Dentist _____
Childhood Diseases & Dates_____
Serious Injuries_____ Surgery_____

Is there anything concerning vision, hearing, or general health of this child that the school should know about in order to provide special care?

_____

TRIP PERMISSION: THIS CHILD HAS MY PERMISSION TO GO ON FIELD TRIPS TAKEN AS PART OF THE SCHOOL PROGRAM UNDER THE SUPERVISION OF A TEACHER.

_____ _____
Date Signature of Parent or Legal Guardian

EMERGENCY AUTHORIZATION INFORMATION

SCHOOL YEAR: _____ BUS #: _____ HOMEROOM TEACHER: _____ GRADE: _____

STUDENT: _____ BIRTH DATE: _____

MAILING ADDRESS: _____ STUDENT CELL #: _____

911 ADDRESS: _____ HOME PHONE: _____

PARENT/GUARDIAN

NAME: _____
RELATIONSHIP TO CHILD: _____
ADDRESS IF DIFFERENT: _____
CELL PHONE: _____
WORK #/EXT: _____
EMAIL ADDRESS: _____

PARENT/GUARDIAN

NAME: _____
RELATIONSHIP TO CHILD: _____
ADDRESS IF DIFFERENT: _____
CELL PHONE: _____
WORK #/EXT: _____
EMAIL ADDRESS: _____

CUSTODY ARRANGEMENTS (NEED COPY ON FILE): _____

NAME OF SITTER: _____ PHONE: _____

IN CASE OF EARLY DISMISSAL/AFTER SCHOOL CANCELLATION, PLEASE INFORM US WHERE YOUR CHILD SHOULD GO? (HOME/SITTER/OTHER)

NAME: _____ PHONE: _____

NAMES AND PHONE NUMBERS OF 2 PEOPLE WHO COULD GET A MESSAGE TO YOU OR COME TO GET YOUR CHILD IF HE/SHE IS ILL:

NAME: _____ PHONE: _____
NAME: _____ PHONE: _____

DOCTOR: _____ HOSPITAL PREFERENCE: _____

NAMES & GRADES OF BROTHERS & SISTERS IN SCHOOL:

NAME: _____ GRADE: _____
NAME: _____ GRADE: _____
NAME: _____ GRADE: _____
NAME: _____ GRADE: _____

N.Y. STATE REQUIRED PHYSICALS FOR STUDENTS IN GRADES Pre K, K, 1st, 3rd, 5th, 7th, 9th, 11th AND NEW STUDENTS.

☐ THE SCHOOL DOCTOR

☐ YOUR OWN PHYSICIAN WITH EXAM FORM FROM SCHOOL.

THE FORM MUST BE RETURNED BY NOVEMBER 1st OR THE PHYSICAL WILL BE SCHEDULED FOR THE SCHOOL TO COMPLETE.

DOES YOUR CHILD HAVE ANY MEDICAL PROBLEMS THE SCHOOL SHOULD KNOW ABOUT?

_____

_____

PERMISSION TO SHARE HEALTH CONDITION WITH CHILD'S TEACHER/TEACHERS.

_____
SIGNATURE OF PARENT/GUARDIAN

_____ _____
SIGNATURE FOR PERMISSION , DATE:

Revised 7/2020

Hermon-DeKalb Central School

STUDENT HEALTH HISTORY UPDATE

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____

_____

Parent/Guardian Signature:_____ Date:_____

HERMON-DEKALB CENTRAL SCHOOL
ENROLLMENT OFFICE
709 East DeKalb Road
DeKalb Junction, NY 13630
Phone: (315) 347-3442
Fax: (315) 347-3817

HOUSING QUESTIONNAIRE

Name of Student: _____
Last First Middle

Gender: ___ Male ___ Female **Date of Birth _____ Grade: _____** **(PreK – 12)** **ID# _____**

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 do not 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 <u>ONE</u>)

___ 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 ANY box other than "In Permanent Housing" is checked, then the student/family should be immediately referred to the MV Liaison. In such cases, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunization.