Alexandria Central School District
34 Bolton Avenue
Alexandria Bay, NY 13607
(315) 482-9971 Main Office
(315) 482-5113 7-12 Office
www.alexandriacentral.org

For Office Use Only

Enroll Date _____ Proofs of Residence _____

Immunization Y or N Birth Certificate Y or N Other _____

Student ID #_____

STUDENT ENROLLMENT FORM

(Revised & Reapproved: 3/24/15)

The information on this form is very important. ***PLEASE PRINT CLEARLY****.*

Student's Name _____ M or F Grade _____
(Last name, First name, Middle initial) *(circle)*

Preferred Name _____ Phone _____ Date of Birth _____

Military Family o Yes o No Coast Guard o Yes o No Border Patrol o Yes o No

Military Branch _____ Unit_____ Civilian Position for Military _____

Ethnic Category (choose one): o American Indian/Alaskan Native o Asian ○ Black/African American

o Hispanic/Latino o Native Hawaiian/Pacific Islander o White/ Caucasian o Multi-Racial _____

Home Address _____
(Number) *(Street)* *(Village/Town)* *(Zip Code)*

Mailing Address (if different and/or P.O. Box) _____

Student's Email Address _____

Previous School Attended _____

Previous School Address or website _____

Name(s) of Brothers and Sisters (Attach additional sheets if necessary):

Name *(Last, First, Middle)*	M or F	Birth date (MM/DD/YY)	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any restricted releases for this child? [Documentation required. Please attach]

_____

If your child had received special education services or accommodations through an Individualized Education Program (IEP) or a Section 504, please sign a consent for the release of special education records so that services can begin as soon as possible.

Parent 1 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address (if different from student) _____

o Lives with student o Has Custody of Student o Should Receive student mailings

Home Phone _____ Work Phone _____ Cell Phone _____

Email address _____

Employer's Name _____ Position _____

Work Address _____

Parent 2 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address (if different from student) _____

o Lives with student o Has Custody of Student o Should Receive student mailings

Home Phone _____ Work Phone _____ Cell Phone _____

Email address _____

Employer's Name _____ Position _____

Work Address _____

If parent / guardian **cannot be reached:**

Emergency Contact 1 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address (if different from student) _____

o Lives with student o Has Custody of Student o Should Receive student mailings

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name _____ Position _____

Work Address _____

Emergency Contact 2 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address (if different from student) _____

o Lives with student o Has Custody of Student o Should Receive student mailings

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name _____ Position _____

Work Address _____

X_____ _____
Parent Signature *Date*

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PARENT/GUARDIAN HOME LANGUAGE IDENTIFICATION SURVEY

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 English. We will use these responses to help determine if your child qualifies for our English as a Second Language program. Thank you for your assistance.

Student's Name _____ School_____

1. What is your relationship to the child? ( ) Mother ( ) Father ( ) Guardian

2. What language did the child learn when he/she first began to talk? _____

3. What language does the family speak in the home most of the time?_____

4. What language does the mother speak to the child most of the time? _____

5. What language does the father speak to the child most of the time? _____

6. What language does the child speak to his/her mother most of the time?_____

7. What language does the child speak to his/her father most of the time?_____

8. What language does the child speak to other adults at home most of the time? _____

9. What language does the child speak to his/her brothers and sisters most of the time?_____

_____ _____
Signature of person completing survey *Date*

New York State Education Department
Office of Bilingual Education
Albany, NY 12234 www.nysed.gov

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HEALTH HISTORY FOR NEW ENTRANTS

Name_____ Sex_____ Grade_____
Address_____ Home Phone_____
Date of Birth_____ Place of Birth_____
Family Physician_____ Physician Phone_____
Dentist_____ Dentist Phone_____
Last Visit to Dentist_____

Check if your child has, or has had, any of the following and provide date when appropriate:

_____ Allergies
_____ Bee Sting
_____ Food
_____ Anemia
_____ Asthma
_____ Cerebral Palsy
_____ Chicken Pox
_____ Frequent Colds & Sore Throats
_____ Convulsions
_____ With Fever
_____ Without Fever
_____ Cystic Fibrosis
_____ Diabetes
_____ Ear Infections
_____ PE Tubes
_____ Eye Condition
_____ German Measles
_____ Hearing Problems
_____ Heart Disease
_____ Hyperkinesis
_____ Kidney Disease
_____ Learning Disabilities
_____ Leukemia
_____ Measles Disease
_____ Mononucleosis
_____ Mumps Disease
_____ Orthopedic Conditions
*Describe*_____
_____ Pneumonia
_____ Rheumatic Fever
_____ Rubella Disease
_____ Scarlet Fever
_____ Speech Problems
_____ Strep Throat
_____ TB
_____ Chest X-ray
_____ TB Contact
_____ TB Test Results
_____ Urinary Infections
_____ Vision Problems
_____ Whooping Cough

Birth Problems (explain)_____

Serious injuries _____

Surgeries _____

Special considerations in school:

A) Daily Medication _____

_____

B) Physical Handicap_____

_____

C) Special Handling in an Emergency_____

_____

Any other problems or conditions that the school should be aware of_____

_____

_____ _____

Date *Signature of Parent or Guardian*

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HEALTH EXAMINATION FORM

Dear Parent or Guardian:

State law requires a medical examination of students upon entrance to school in grades 2,4,7 and 10, and at any other time deemed necessary by school officials. This is to identify early health problems and to maintain accurate records of the student's health status. Each school district is mandated by law to provide an examination by the school physician of those students whose parents do not provide a report from a family physician.

Privacy is provided and the school nurse is present and assists during the examination.

The following items are examined: skin, hair, eyes, ears, nose, teeth and gums, thyroid and lymph nodes, chest and heart, abdomen, external genitalia (male), bones, feet and joints. The child's height, weight, and blood pressure are also checked at that time and entered on their health record.

NO ONE CAN PARTICIPATE IN ATHLETICS PRIOR TO A HEALTH EXAMINATION.

Any parent who does not wish to have the school physical examination for their child should complete the form below and return it to the nurse as soon as possible.

I prefer to have _____ examined by our family physician.

_____ on _____
(name of physician) (date)

I will have a report of this examination to the school within 30 days o the examination date.

Signature of Parent / Guardian _____

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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Dear Parent or Guardian:

In the event that my child is injured or becomes ill and is in need of a physician, dentist, or hospitalization, and I cannot be reached, I authorize Alexandria Central School and/or personnel to obtain Medical, Dental, Hospital or Ambulance attention as needed.

Name of Minor _____ Birth Date _____

Parent or Guardian _____

Address _____

Home Phone _____ Emergency Phone _____

Please identify allergies, drug allergies, or special medical considerations:

Allergies _____

Drug Allergies _____

Special Medical Conditions _____

_____

This document shall be presented to a physician, dentist, hospital, or appropriate representative if needed.

Signature of Parent / Guardian _____

Hospitalization coverage for the above named minor:

Name of Insurance Company _____

ID or Contract Number _____

Family Physician _____ Physician Phone _____

Dentist _____ Dentist Phone _____

Last Visit to Dentist_____

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REQUIRED IMMUNIZATIONS FORM

Public Health Law 2164 requires that the following immunizations be received prior to the child being allowed to enter school:

__ **3 OPV or 4 IPV (polio vaccine).** If combination of OPV and IPV are given, the total number of doses should be at least 4.
__ **3 DPT, DTaP, or DT (diphtheria-pertussis-tetanus vaccine).** FULL DOSES ONLY.
__ **1 Measles vaccine (after first birthday).**
__ **1 Mumps vaccine (after first birthday).**
__ **1 Rubella vaccine (after first birthday).**
__ **1 Measles booster (after 15 months)** for all children born on or after 01/01/1985.
__ **3 Hepatitis B vaccine** for all children born on or after 01/01/1993 and all students entering seventh grade on or after September 2000.
__ **1 Varicella vaccine (after first birthday)** for all children born on or after 01/01/1998 and all children born on or after 01/01/1994 who enroll in sixth grade, **or physician documentation regarding history of disease.**

The district needs proof of compliance with this law at the time you register your child into the school district. Adequate proof is written certificate or record from the physician's office, a transcript from the previous school, or a certificate of religious or medical exemption.

If the immunizations have not been completed by the date your child is to enter school, **we must exclude the child from school** until the immunizations have been completed or until proof of satisfactory progress toward this completion is shown. Please be advised that the law requires us to exclude children for up to two weeks if the process is not taking place and that, after two weeks of exclusion, we are required to notify Child Protective Services.

STUDENT'S NAME _____ **Date of Birth** _____

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
OPV (3)	___/___/___	___/___/___	___/___/___	___/___/___	
IPV (4)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DPT,DTaP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Measles	___/___/___	___/___/___			
Mumps	___/___/___				
Rubella	___/___/___				
MMR	___/___/___	___/___/___			
Hepatitis B	___/___/___	___/___/___	___/___/___		
Varicella	___/___/___	**History of Disease on** ____/___/___			
HIB	___/___/___	___/___/___	___/___/___	___/___/___	
Other	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

Physician's Signature _____ **Date** _____

Physician's name or stamp _____

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INFORMATION FOR SCHOOL NURSE

NAME _____
ADDRESS _____

SEX _____ GRADE _____ DOB _____

FATHER'S NAME _____
MOTHER'S NAME _____

HEIGHT _____
WEIGHT _____
BLOOD PRESSURE _____
VISION R ____L____
HEARING R ____L____

LYMPH NODES _____
THYROID _____
NOSE _____
TONSILS _____
TEETH _____
HEART _____
LUNGS _____

LEAD LEVEL _____
BMI _____
Weight Status Category (BMI %)
__Less than 5th __5th -49th
__50th -84th __85th-94th
__95TH-98TH __99TH -

FEET _____
SKIN (Non Comm) _____
EPILEPSY _____
NERVOUS SYSTEM _____
SPEECH _____
NUTRITION _____
HERNIA _____
OTHER _____

Has this child, during the past year, had any illness or operations?

Dates of immunizations if given in the office:

Varicella (chicken pox) _____
Hepatitis_____
Polio Vaccine_____
MMR_____
HIB_____
Prevnar_____
Tuberculin Test_____
*Medical Recommendations _____

Physician's Signature: _____ Date:_____

Alexandria Central School District

Safe and Acceptable Use of Electronic Technology

New Student Version

The Alexandria Central School District (ACSD) is committed to providing students access to technology in order to enhance opportunities in education. To aid in this process ACSD provides students access to the district's computer network, which includes Internet access. It is expected that student use of the ACSD computer network is for educational purposes.

Please be advised that ACSD has filtering/blocking technology on those computers with Internet access. However, this technology does not guarantee that students will be blocked from accessing all inappropriate sites.

It is imperative that students conduct themselves in a responsible and legal manner while using ACSD's computer network. This policy provides general guidelines for students. Final determination of acceptable behavior rests with ACSD school administration.

PRIVILEGE

The use of the district's computer network is a privilege, not a right, and inappropriate activity may result in cancellation of those privileges. The ACSD school administration may close an account at any time.

MONITORING

ACSD's computer equipment and network is monitored for maintenance, safety, and to ensure the students are following this policy. The district reserves the right to inspect the contents of files stored on the computer network at any time.

PROHIBITED ACTIVITY AND USES

1. Only ACSD's computer equipment may access ACSD's computer network.
2. Using ACSD's computer equipment or network for commercial activity.
3. Using ACSD's computer equipment or network in a manner that violates any copyrights or other intellectual property rights.
4. Using ACSD's computer equipment or network to receive, transmit, or make available to others obscene or offensive material.
5. Using ACSD's computer equipment or network to receive, transmit or make available to others material that is racist, sexist, abusive, obscene or harassing to others.
6. Using another student's account or password to log on onto to the ACSD computer network or log onto any website, database, or educational site that ACSD has provided students with individual accounts.
7. Using ACSD's computer equipment or network in a manner that disrupts others use or invades the privacy of others.
8. Using ACSD's computer equipment or network in a fashion inconsistent with directions from teachers and other staff.

Please return this form signed to Lily Gionet, Educational Technologist. Students who do not return this form will have their account privileges removed.

I have read the preceding Acceptable Use Policy and understand that I will be held accountable for complying with its terms.

Student Name (Print)	Student Name (Signature)	Date

As a parent / guardian of a minor I have read the Acceptable Use Policy and understand that the individual student will be held accountable for complying with its terms.

Parent Guardian Name (Print)	Parent Guardian Name (Signature)	Date

Alexandria Central School District
School Records
34 Bolton Avenue
Alexandria Bay, New York 13607
(315) 482-9971 Main Office
(315) 482-5113 7-12 Office
(315) 482-9973 Fax

Authorization for the Release or Transfer of Information

Student Name:_____

Name and address of school last attended:

School:_____
Address:_____
_____
Phone and /or Fax:_____
School Website:_____

The above student has enrolled in our school district**. Please forward all school records including health, psychological, academic and other data.** Thank you for your assistance.

_____ _____
Signature of Parent or Guardian Date

MAIL TO:

Alexandria Central School - Records
34 Bolton Avenue
Alexandria Bay, New York 13607
(315) 482-9973 Fax

Date Mailed:

.

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ /____ /____ Grade: ___ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

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**. **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 immunizations.

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

FORMULARIO DE INSCRIPCIÓN – CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar:

_____

Nombre de la Escuela:

_____

Nombre del Estudiante:

_____

Apellido Primer Nombre Segundo Nombre

Género ☐ Hombre ☐ Mujer Fecha de Nacimiento: ___/___/_____ Grado: ____ ID#: _____

Mes Dia Ano *(jardín de infantes – 12)* *(opciónal)*

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

Donde está el estudiante viviendo actualmente? (*Por favor marque **una** caja*.)

- ❑ En un refugio
- ❑ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ❑ En un hotel/motel
- ❑ En un carro, parque, autobús, tren, o camping
- ❑ Otra vivienda temporal (Por favor describa):

  _____
- ❑ En un hogar permanente

_____ _____

Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____

Fecha

Si el estudiante **NO** vive en un hogar permanente, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

ATENCIÓN ESCUELAS Y DISTRITOS: Si el estudiante **NO** vive en un hogar permanente, favor de asegúrese que una Formulario de Designación sea completado.