



**CORNWALL**  
CENTRAL SCHOOL DISTRICT

## STUDENT REGISTRATION OFFICE

[www.cornwallschools.com](http://www.cornwallschools.com)

***Welcome to the Cornwall Central School District!***

Please complete the online Cornwall Pre-Registration form: <https://st-cw.mhric.org/Cornwall/onlinepreregistration/>

Attached is the Cornwall Central School District enrollment packet (grades K-12) for you to complete. PRINT SINGLE SIDED

The following documents are **required** at time of registration:

- **Two (2) proofs of residency:**
  - If you **own** your home, provide a current tax bill **OR** a current mortgage statement **AND** a current utility bill.
  - If you **rent** your home, provide a current lease **AND** a current utility bill.
  - If you are residing with family, please call the Registrar for a CCSD Resident Affidavit.
- **birth certificate**
- **most recent report card** (please contact your child's school to obtain a copy)
- **disciplinary records** (if applicable)
- **immunizations up-to-this date**
- **Your child will need a physical completed in New York State within one year of starting school.**  
**Your child has 15 days after his/her first day of school to provide a NYS physical to the school nurse.**
- **High School Students Who Would Like To Participate In High School Athletics (grades 9-12 only) – NYSPHSAA Transfer Notification Form and Transfer Student Information Form**

Please submit all required registration documents together as missing or incomplete documents will delay the registration process. Submit all required registration documents via email, mail or deliver to the Central Registration Office located at the High School Building (office hours Monday - Friday 8:30am- 1:00pm).

*Crystal O'Brien*

*Central Registrar*

*Cornwall Central High School*

*10 Dragon Drive*

*New Windsor, NY 12553*

*Phone: 845-534-8009 x7803 Fax: 845-314-8818*

*cobrien@cornwallschools.com*

**CORNWALL CENTRAL SCHOOL DISTRICT  
ENROLLED STUDENT INFORMATION FORM**

**STUDENT'S NAME:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_  
*First Middle Last*

**DATE OF BIRTH:** \_\_\_\_\_ **GENDER:**  Male  Female

**PLACE OF BIRTH:** \_\_\_\_\_  
*City & State / Country if not USA*

**DATE OF ENTRY INTO THE USA:** \_\_\_\_\_ **YEARS IN USA SCHOOLS:** \_\_\_\_\_

**IS EITHER PARENT OR LEGAL GUARDIAN AN ACTIVE DUTY MEMBER OF THE ARMED FORCES? IF YES, PLEASE SPECIFY BELOW:**

Name: \_\_\_\_\_ Branch of Service: \_\_\_\_\_ Entry Date: \_\_\_\_\_ Exit Date: \_\_\_\_\_

Name: \_\_\_\_\_ Branch of Service: \_\_\_\_\_ Entry Date: \_\_\_\_\_ Exit Date: \_\_\_\_\_

**ETHNICITY:**  **Yes**, Hispanic/Latino  **No**, Not Hispanic/Latino  
*Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South America, or other Spanish culture or origin, regardless of race.*

**RACE:** *You may choose one or more*

- Am Indian/Alaska Native** - A person having origins in North America and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.
- Asian** - A person having origins in any of the origins of the Far East, Southeast Asia, or the Indian subcontinent.
- Native Hawaiian/Pacific Islander** - A person having origins in Hawaii, Guam, Samoa, or other Pacific Islands.
- Black/African American** - A person having origins in any of the Black racial groups of Africa.
- White** - A person having origins in Europe, North Africa or the Middle East.

\_\_\_\_\_  
*Signature of Parent / Guardian*

\_\_\_\_\_  
*Date*

*\*This information is gathered pursuant to New York State and Federal requirements, but is not used to make a determination with respect to a student's right to register and enroll in the Cornwall Central School District.*

**CORNWALL CENTRAL SCHOOL DISTRICT**

**STUDENT REGISTRATION OFFICE – 10 DRAGON DRIVE, NEW WINDSOR, NY 12553**

**PHONE: 845-534-8009 x7803**

STUDENT'S NAME \_\_\_\_\_ GENDER: MALE  FEMALE  GRADE: \_\_\_\_\_  
First Middle Last

DATE OF BIRTH: \_\_\_\_\_

PARENT MARITAL STATUS \_\_\_\_\_ Is there a custody issue with this child? \_\_\_\_\_ If yes, who has custody? \_\_\_\_\_

ORDER OF PROTECTION \_\_\_\_\_ *If an order of protection exists, please submit a copy to your child's principal at time of student enrollment.*

SIBLINGS RESIDING AT HOME			
NAME OF SIBLING	DATE OF BIRTH	GRADE	SCHOOL ATTENDING

STUDENT'S EDUCATIONAL BACKGROUND		
SCHOOL NAME	CITY/STATE	ATTENDED: GRADE / YEAR

Has your child been retained (repeated a grade)?  Yes  No If yes, what grade? \_\_\_\_\_

Has your child received:  Counseling  Speech  Remedial Math  Remedial Reading  Other \_\_\_\_\_

Does your child have an Individual Education Plan (IEP)? Yes \_\_\_\_\_ No \_\_\_\_\_ At what were services provided? \_\_\_\_\_

**EMERGENCY CONTACTS: Local person who have agreed to care for your child in an emergency when parents cannot be reached:**

*In an emergency situation, Administration will take any action it deems necessary and appropriate, including taking your child to the hospital.*

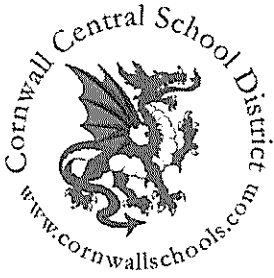
#1 \_\_\_\_\_  
Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ City/State (**MUST BE LOCAL**) \_\_\_\_\_  
\_\_\_\_\_ \_\_\_\_\_  
Home Phone # Cell Phone #1 Cell Phone #2 Work Phone #

#2 \_\_\_\_\_  
Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ City/State (**MUST BE LOCAL**) \_\_\_\_\_  
\_\_\_\_\_ \_\_\_\_\_  
Home Phone # Cell Phone #1 Cell Phone #2 Work Phone #

\_\_\_\_\_  
Signature of Parent, Guardian Relationship Date

\_\_\_\_\_ Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camp ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement \_\_\_\_\_ (living arrangements). If box is checked, please complete STAC-202 form. The answer you give 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.

Is this a foster placement: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, name of county: \_\_\_\_\_  
*If yes, copy of DSS 2999 Form required*



# Cornwall Central School District

## **COMPUTER USE AND PHOTO PERMISSION FORM**

Cornwall Central School District wishes to provide students, educators and community with a useful computer information system. Our computer network, e-mail system, internet access policy and district website serve to help our staff and students conduct research, produce material and communicate. All Students have access to this system. Abuse or misuse of the computer system may subject a student to have use rights removed as per the Code-of-Conduct.

To highlight the accomplishments and or engagement of our students, there are often occasions when a building administrator or teacher will want to publish photographs and/or videos of students engaged in school-related activities while on School District property or at School District sponsored functions to the School District's website or to select social media sites monitored and edited by the School District such as Facebook or Twitter. **Student's name will not be included.**

If you do not want the District to use your child's image or likeness on the District's website or sponsored social media sites, please sign and return the slip below.

If you have any questions or concerns, please contact your child's principal.

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\_\_\_\_\_ **NO, I do not want my child's picture to be posted on the School District's website, district sponsored social media forums i.e., Facebook, Twitter**

\_\_\_\_\_ **YES, I give CCSD permission to post my child's picture.**

\_\_\_\_\_  
**CHILD'S NAME**

\_\_\_\_\_  
**BUILDING**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PRINT PARENT / GUARDIAN'S NAME**

\_\_\_\_\_  
**PARENT / GUARDIAN SIGNATURE**



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.

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not write

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

SCHOOL DISTRICT INFORMATION:

Cornwall Central School District

District Name (Number) & School:

Address:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

## 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:  Parent     Other: \_\_\_\_\_

#### OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: Crystal O'Brien    POSITION: Central Registrar

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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

# CORNWALL CENTRAL SCHOOL DISTRICT

## SCHOOL TRANSPORTATION REQUEST FORM – PUBLIC SCHOOL

Today's Date: \_\_\_\_\_ SCHOOL YEAR: \_\_\_\_\_ START DATE: \_\_\_\_\_

Student's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ M \_\_\_\_\_ F

Home Address: \_\_\_\_\_  
(Street address, city, state, zip code)

Mailing Address (if different from above): \_\_\_\_\_  
(Street address, city, state, zip code)

Parent/ Guardian Name(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_

Email: \_\_\_\_\_

School: HS  MS  CES  WAE  COH  Grade: \_\_\_\_\_

- NEW STUDENT  NEW ADDRESS (SEE BELOW)  NEW CHILDCARE  CHANGE IN SCHOOL  
 OTHER (please explain): \_\_\_\_\_

**CHANGE OF ADDRESS WILL REQUIRE PROOF OF RESIDENCY AND MUST BE PRESENTED TO:**  
Central Registrar, Crystal O'Brien PH: 845-534-8009 x7803 Email address: [cobrien@cornwallschools.com](mailto:cobrien@cornwallschools.com)

### REQUEST:

- \_\_\_\_\_ Transportation to/from **HOME** address.  
\_\_\_\_\_ Transportation with **CHILDCARE** arrangements.  
\_\_\_\_\_ **WALKER/PARENT TRANSPORT** - transportation not required.

### CHILDCARE TRANSPORTATION (within CCSD)

#### A.M. PICK UP:

Check: \_\_\_\_\_ Home \_\_\_\_\_ Childcare Provider \_\_\_\_\_ Walker

Providers Name: \_\_\_\_\_

Providers Address: \_\_\_\_\_

Providers Phone: \_\_\_\_\_

Days:  Mon  Tues  Wed  Thurs  Fri

#### P.M. DROP OFF:

Check: \_\_\_\_\_ Home  Childcare Provider \_\_\_\_\_ Walker

Providers Name: \_\_\_\_\_

Providers Address: \_\_\_\_\_

Providers Phone: \_\_\_\_\_

Days:  Mon  Tues  Wed  Thurs.  Fri

Does your child have any medical concerns we should know about, ie, allergies, etc.? Please explain:

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return to: Transportation Coordinator

PH: 845-534-8009 x7100 FAX: 845-534-9032 Email address: [transportation@cornwallschools.com](mailto:transportation@cornwallschools.com)\*\* PLEASE NOTE  
TRANSPORTATION CHANGES TAKE APPROX 48 HOURS or longer during the first week of school\*\*

FOR OFFICE USE ONLY: NEW STUDENT: \_\_\_\_\_ (YES OR NO) STUDENT ID#: \_\_\_\_\_ Parent Notified: \_\_\_\_\_

BUS RUN #: \_\_\_\_\_ A.M. P/U TIME: \_\_\_\_\_ Location: \_\_\_\_\_ P.M. D/O TIME: \_\_\_\_\_ Location: \_\_\_\_\_



# Cornwall Central School District

## STUDENT HEALTH OFFICES

(845) 534-8009

High School  
Ext. 5010

Middle School  
Ext. 4010

Cornwall on Hudson Elementary  
Ext. 1010

Cornwall Elementary  
Ext. 2010

Willow Avenue Elementary  
Ext. 3010

Student's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent email: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home phone #: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work#: \_\_\_\_\_

### Student's Medical History

Has your child ever had the following Communicable Diseases:

	<u>Yes</u>	<u>No</u>	<u>Date</u>		<u>Yes</u>	<u>No</u>	<u>Date</u>
Chicken Pox	_____	_____	_____	Scarlet Fever	_____	_____	_____
Mumps	_____	_____	_____	Whooping Cough	_____	_____	_____
German Measles	_____	_____	_____				

1) Is your child presently under treatment for any physical problem? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, explain: \_\_\_\_\_

2) Does your child take medication on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, name of medication and reason \_\_\_\_\_

**If your child needs to take medication during the school day, you must contact the Health office in person. Specific forms must be filled out and signed by your Physician before ANY medication can be administered.**

3) Has your child ever had surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

4) Has your child had any serious medical problems? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

5) Has your child had a serious accident or injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

6) Has your child ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

7) Does your child have any allergies to food, medication or insects/bee stings? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

8) Does your child wear glasses or contacts? Yes \_\_\_\_\_ No \_\_\_\_\_ Other visual difficulties, please explain: \_\_\_\_\_

9) Does your child have any:

Ear problems?	Yes _____	No _____
Hearing loss?	Yes _____	No _____
Frequent ear infections?	Yes _____	No _____
Tubes in ears?	Yes _____	No _____

At what age? \_\_\_\_\_

Explain: \_\_\_\_\_

10) Does your child have any speech difficulties? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

11) Does your family have any history of diabetes or tuberculosis? Yes \_\_\_\_\_ No \_\_\_\_\_

Family Physician: \_\_\_\_\_  
Name City/State Phone #

**In emergency situations, Administration will take any action it deems necessary & appropriate, including taking your child to the hospital.**

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CORNWALL CENTRAL SCHOOL DISTRICT - CORNWALL, NY**

**CORNWALL CENTRAL SCHOOL DISTRICT - CORNWALL, NY**

**\*\* REQUEST FOR STUDENT RECORDS \*\***

*District Phone Number (845) 534-8009*

**PRIOR SCHOOL:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Student's Name:** \_\_\_\_\_ **Student's DOB:** \_\_\_\_\_

The above named student has enrolled in the Cornwall Central School District. Please forward to us the items listed below and any other pertinent information which will assist us in placing and supporting this student. Thank you.

- Official Transcript
- Health / Immunization Records
- Standardized Test Scores
- School Profile
- Course Selections/Recommendations for the new school year
- Discipline Records
- RCT Scores
- Copy of last Report Card
- Graduation Requirements
- Withdrawal Grades for current year
- Copy of I E P
- Behavior Intervention Plan or 504
- Psychological Reports (if any)
- Speech Evaluations (if any)
- OT / PT Evaluations (if any)
- Vision Evaluation (if any)
- Other: \_\_\_\_\_

Please send records listed above to the attention of \_\_\_\_\_

\_\_\_\_\_ **Cornwall Central High School**  
10 Dragon Drive  
New Windsor, NY 12553  
**Fax: 845-565-4931**

\_\_\_\_\_ **Cornwall Elementary School**  
99 Lee Road  
Cornwall, NY 12518  
**Fax: 845-534-0569**

\_\_\_\_\_ **Cornwall Central Middle School**  
122 Main Street  
Cornwall, NY 12518  
**Email: amilani@cornwallschools.com**

\_\_\_\_\_ **Willow Avenue Elementary School**  
67 Willow Avenue  
Cornwall, NY 12518  
**Fax: 845-314-9424**

\_\_\_\_\_ **Cornwall on Hudson Elem. School**  
234 Hudson Street  
Cornwall on Hudson, NY 12520  
**Fax: 845-534-2284**  
**Email: pshilling@cornwallschools.com**

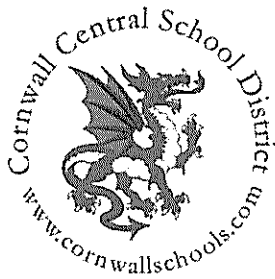
\_\_\_\_\_ **Office of Pupil Personnel Services**  
10 Dragon Drive  
New Windsor, NY 12553  
**Fax: 845-314-8640**

I hereby authorize the release of the records listed above.

\_\_\_\_\_  
*Signature of Student (if over 18)*

\_\_\_\_\_  
*Signature of Parent / Guardian*

\_\_\_\_\_  
*Date*



# Cornwall Central School District

Terry Dade  
*Superintendent of Schools*

Harvey Sotland  
*Assistant Superintendent for Business*

Megan Argenio  
*Assistant Superintendent for Instruction*

**THIS FORM MUST BE RETURNED WITH PHOTO IDENTIFICATION**

Dear Parent / Guardian:

The Cornwall Central School District is introducing the Parent Portal of our SchoolTool Student Management Information System to Parents/Guardians. You will have access to view the following information for your child: emergency contact information, schedule, attendance, report card grades including progress reports, past assessment scores/past exam grades.

To create an account for viewing this information, please complete the bottom portion of this letter and either bring it to the main office of your child's school or return the form to school with a copy of your current photo ID with your child. Once the form is received at the school and processed, an account will be created. You will receive an email with your first SchoolTool password and instructions on how to access your portal account. Please note that this process only needs to be completed once, not every year. One form will cover all children in your family. SchoolTool is a secure internet site; however, parents/guardians are responsible for protecting their password.

If you have any questions or concerns, please contact the main office your child's building.

-----  
*Please keep top portion of this letter for your records.*

Parents/Guardians must provide valid picture identification. Accounts will not be created without proper identification.

Name of Parent/Guardian: \_\_\_\_\_

Parent/Guardian email address: \_\_\_\_\_

**PLEASE PRINT LEGIBLY**

Name of child(ren):

\_\_\_\_\_  
Child's name                      Grade/School                      Child's name                      Grade/School

\_\_\_\_\_  
Child's name                      Grade/School                      Child's name                      Grade/School

Signature of Parent/Guardian: \_\_\_\_\_

**BUILDING VERIFICATION**

Type of Photo ID: \_\_\_\_\_ Date: \_\_\_\_\_

Date form received: \_\_\_\_\_

Photo ID received by: \_\_\_\_\_

Date account created: \_\_\_\_\_

**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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

**HEALTH HISTORY**

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

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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/m<sup>2</sup>

Percentile (Weight Status Category):  < 5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

Hyperlipidemia:  Yes  Not Done      Hypertension:  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

Height:	Weight:	BP:	Pulse:	Respirations:	
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level Required for PreK &amp; K</b>	<b>Date</b>
TB-PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5$ $\mu\text{g/dL}$	
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>			

System Review Within Normal Limits

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

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:	Affirmed Name (if applicable):	DOB:
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**SCREENINGS**

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

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.	<b>Not Done</b>			
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes	<input type="checkbox"/>

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	<b>Not Done</b>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

**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
<input type="checkbox"/> Confirmed free of communicable disease during exam	<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIS

**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.**



# TRANSFER NOTIFICATION

This form must be completed for all transfer students and submitted to:

**UPON RECEIPT OF PART ONE IN THE SECTION OFFICE, THE STUDENT IS ELIGIBLE TO PRACTICE; BUT CANNOT PARTICIPATE IN A CONTEST UNTIL APPROVED BY THE SECTION.**

Please check one: **(The required supporting documentation must be attached.)**

**Waiver Request** *Financial: Requires documented proof of a significant loss of income or a significant increase in expenses. OR Health & Safety: Written documentation from the Superintendent of Schools or HS Principal of the sending school indicating the specific circumstances which necessitated the transfer and must be accompanied by supporting documentation (i.e. police report, DASA report, etc)*

**Return to School District of Residence (RSDR)** (No change of residence. School registration change only.) Student is returning to a school within the district boundaries of his/her residence.

**Divorced/Legally Separated Parents** *A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six months. The legal separation agreement must address custody, child support, spouses support and distribution of assets and be filed with the County Clerk or issued by a Judge.*

**Homeless** Student declared homeless by the Superintendent under McKinney-Vento Legislation [NYSSED 100.2].

**Residency Change** *NYSPHSAA transfer/residency policy states: Refer to By-Law & Eligibility Standards #30. (A residency is changed when one is abandoned and another one established through action and intent. Residency requires one's physical presence as an inhabitant and the intent to remain indefinitely. The mere renting of property within the District does not confer residency. The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA regulations.*

**Other Transfer Exemption:** \_\_\_\_\_

**By signing this document I attest that our previous residence has been abandoned by the immediate family and our current residence has been established through action and intent. I attest that the immediate family will be physically residing at our current address as inhabitants and intent to main indefinitely. I attest that the student has transferred without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.**

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent's Name: \_\_\_\_\_

## PART ONE TO BE COMPLETED BY STUDENT'S RECEIVING SCHOOL

Receiving School: \_\_\_\_\_ Student's Name: \_\_\_\_\_

Date of Transfer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Date Entered 9<sup>th</sup> Grade: \_\_\_\_\_

Student/Family Previous Address: \_\_\_\_\_

Student/Family Present Address: \_\_\_\_\_

Parent's Names and Current Address(es)  
**(Parent I name & address)** \_\_\_\_\_

**(Parent II name & address)** \_\_\_\_\_

Name of Sending School \_\_\_\_\_

Did student participate in athletics at sending school? Yes No

The undersigned hereby certify that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

The receiving school's administration is responsible for verification for these and other eligibility requirements.

Superintendent's signature \_\_\_\_\_ Date \_\_\_\_\_

Principal's signature \_\_\_\_\_ Date \_\_\_\_\_

Athletic Director's signature \_\_\_\_\_ Date \_\_\_\_\_

**PART TWO TO BE COMPLETED BY SCHOOL STUDENT PREVIOUSLY ATTENDED  
AND RETURNED TO STUDENT'S PRESENT SCHOOL**

Name of Student \_\_\_\_\_ Date entered 9<sup>th</sup> grade \_\_\_\_\_

Did student repeat any grades? \_\_\_\_\_ If yes, which ones? \_\_\_\_\_

Name of School(s) Attended Prior to Transfer \_\_\_\_\_

Date of entrance to this school \_\_\_\_\_ Date of withdrawal from this school \_\_\_\_\_

Student's address while attending the above school \_\_\_\_\_

With whom did student reside at this address (name)? \_\_\_\_\_

Relationship of this (these) person(s)? \_\_\_\_\_

**PART THREE - TRANSFER STUDENT SPORT HISTORY (Please include all sports student participated in.)**

Year	Sport	Level	APP'd (Sel. Class.)		School
7th Grade	_____	_____	Yes	No	_____
	_____	_____	Yes	No	_____
	_____	_____	Yes	No	_____
8th Grade	_____	_____	Yes	No	_____
	_____	_____	Yes	No	_____
	_____	_____	Yes	No	_____
9th Grade	_____	_____			_____
	_____	_____			_____
	_____	_____			_____
10th Grade	_____	_____			_____
	_____	_____			_____
	_____	_____			_____
11th Grade	_____	_____			_____
	_____	_____			_____
	_____	_____			_____
12th Grade	_____	_____			_____
	_____	_____			_____
	_____	_____			_____

The undersigned have no knowledge that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

Superintendent's signature \_\_\_\_\_ Date \_\_\_\_\_

Principal's signature \_\_\_\_\_ Date \_\_\_\_\_

Athletic Director's signature \_\_\_\_\_ Date \_\_\_\_\_

TO BE USED BY GUIDANCE OFFICES FOR ALL  
TRANSFERS AND FORWARDED TO  
ATHLETIC DIRECTORS

TRANSFER STUDENT INFORMATION

All transfers in grades 9-12 must complete this form. Upon completion, forward to the Athletic Office.

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date of transfer \_\_\_\_\_ Grade level \_\_\_\_\_  
Current Address \_\_\_\_\_

**Date of entrance into the ninth grade** \_\_\_\_\_

Parents' Names \_\_\_\_\_  
Current Address (es) \_\_\_\_\_

Telephone Numbers \_\_\_\_\_

How long has student resided at the current address? \_\_\_\_\_

With whom is student residing? \_\_\_\_\_

Relationship of this (these) person(s)? \_\_\_\_\_

Reason for transfer \_\_\_\_\_

\*\*\*\*\*

Student's previous address \_\_\_\_\_

How long did student reside at previous address? \_\_\_\_\_

With whom did student reside at previous address? \_\_\_\_\_

Relationship of this (these) person(s)? \_\_\_\_\_

PREVIOUS SCHOOL \_\_\_\_\_

Previous School Address \_\_\_\_\_

Date of entry into previous school \_\_\_\_\_

Did student participate in interscholastic athletics at previous school?

YES  NO

If Yes, please complete Sport History page.



REQUEST FOR WAIVER OF  
NYSPHSAA ELIGIBILITY STANDARD #31 – TRANSFER

INCOMPLETE OR PARTIAL FORMS WILL NOT BE ACCEPTED

All three pages MUST be completed in order for a request to be considered for transfer public to private or private to private.

Only this page needs to be completed private to public returning to his/her school district of residency.

PAGE ONE TO BE COMPLETED BY STUDENT'S PRESENT SCHOOL

School submitting request \_\_\_\_\_  
Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date of Transfer \_\_\_\_\_ Grade Level \_\_\_\_\_  
Current Address \_\_\_\_\_  
Parent's Names \_\_\_\_\_  
Current Address(es) \_\_\_\_\_  
Telephone Number(s) \_\_\_\_\_  
How long has student resided at the current address? \_\_\_\_\_  
With whom is student residing? \_\_\_\_\_  
Relationship of this (these) person(s) \_\_\_\_\_  
Reason for transfer \_\_\_\_\_  
(Attach supporting material and documentation.)  
Previous School/Address \_\_\_\_\_

TO BE SIGNED BY SCHOOL ADMINISTRATORS OF SCHOOL WHERE STUDENT IS CURRENTLY ENROLLED AFTER RECEIPT OF PAGES TWO AND THREE FROM THE SCHOOL STUDENT PREVIOUSLY ATTENDED:

The undersigned hereby certify that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage.

Superintendent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_

Athletic Director's Signature \_\_\_\_\_ Date \_\_\_\_\_

- 
- APPROVED Signature \_\_\_\_\_ Date \_\_\_\_\_  
 DISAPPROVED Thomas Cassata  
Section IX Eligibility Chairperson  
 REFERRED TO ELIGIBILITY COMMITTEE

PAGE TWO TO BE COMPLETED BY SCHOOL STUDENT PREVIOUSLY ATTENDED AND RETURNED TO STUDENT'S PRESENT SCHOOL

Name of Student \_\_\_\_\_

Name of School Student Attended Prior to Transfer \_\_\_\_\_

Address of School \_\_\_\_\_

Date of entrance to this school \_\_\_\_\_

Date of entrance into the ninth grade \_\_\_\_\_

Date of withdrawal from this school \_\_\_\_\_

Reason for withdrawal \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student's address while attending the above school \_\_\_\_\_

\_\_\_\_\_

With whom did student reside at this address? \_\_\_\_\_

Relationship of this (these) person(s)? \_\_\_\_\_

Did student participate in interscholastic athletics at previous school? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please complete Sport History page three.

\_\_\_\_\_

The undersigned have no knowledge that the student named herein has transferred to his/her present school with inducement, recruitment or having sought an athletic advantage.

Superintendent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Principal's Signature \_\_\_\_\_ Date \_\_\_\_\_

Athletic Director's Signature \_\_\_\_\_ Date \_\_\_\_\_

If unsigned, please state reason(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAGE THREE**  
**TRANSFER STUDENT SPORT HISTORY**

\_\_\_\_\_  
**Student Name**

\_\_\_\_\_  
**School**

	<u>YEAR</u>	<u>SPORT</u>	<u>LEVEL</u>	<u>SCHOOL</u>
9 <sup>th</sup> Grade	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____
10 <sup>th</sup> Grade	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____
11 <sup>th</sup> Grade	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____
12 <sup>th</sup> Grade	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____

\_\_\_\_\_  
Athletic Director Signature

\_\_\_\_\_  
Date

NEW YORK STATE PUBLIC HIGH SCHOOL  
ATHLETIC ASSOCIATION, INC.

SECTION NINE  
DURATION OF COMPETITION  
EXTENSION APPLICATION (Standard 8i)  
TO BE FORWARDED TO ELIGIBILITY COMMITTEE

I. Personal Data

Pupil Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_  
 School Telephone #: \_\_\_\_\_  
 Seasons and Sports Requested: \_\_\_\_\_  
 Pupil's Athletic History: \_\_\_\_\_

Sport	No. of Seasons Participated	School Years
_____	_____	_____
_____	_____	_____
_____	_____	_____

II. Date of Entry (Beginning of Sport Participation in High School Level of Competition). Attach Transcript

A. Date of entry into ninth grade: \_\_\_\_\_  
 Month Day Year  
 B. Date of entry into eighth grade: \_\_\_\_\_  
 Month Day Year  
 C. Date of entry into seventh grade: \_\_\_\_\_  
 Month Day Year

III. Reason for Request for Extension

Describe the reason for requesting an extension for duration of Competition as it relates to the appropriate circumstance and attach supporting documents providing such evidence. The evidence must include documentation showing that as a direct result of the illness, accident, or similar circumstance, the pupil will be required to attend school for one or more additional semesters in order to graduate.

A. Illness: \_\_\_\_\_  
 \_\_\_\_\_  
 B. Accident: \_\_\_\_\_  
 \_\_\_\_\_  
 C. Other Circumstances: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Superintendent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athletic Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

APPROVED

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Thomas Cassata, Eligibility Chairperson

DISAPPROVED