

Welcome to the Cato-Meridian Central School District!

Steps for Registering a Student

- 1). Please fill out the Registration packet in its entirety. All information is required.
- 2). Once the packet is filled out, please call the appropriate office to set up an appointment to drop off the completed packet **and** necessary additional documents.
 - Grades PreK - 6: 315-626-3439 ex 1801 or 1803
 - Grades 7-12 : 315-626-3439 ex 3821

What necessary additional documents do you need to provide for registration?

For **ALL** new registrants:

- Proof of residency in the Cato-Meridian Central School District (only 1 is needed)
 - Homeowners: mortgage statement
 - Renters: Lease agreement
 - Current utility bill in parent/legal guardian name (gas, electric, cable)
- Custody paperwork (if applicable)

For registrants entering school for the first time (UPK, Pre-K, K or previously Homeschooled) you will also need:

- Birth Certificate
- Immunization records/Health records
- Current Physical (within the last year)

If you have any questions, please don't hesitate to reach out either by phone or by email!

Erin Barnhart
Jr/Sr High School Counseling Secretary
Central Registrar
(315) 626-3439 ex 3821
ebarnhart@catomeridian.org

THIS SECTION FOR OFFICE USE ONLY	Student ID:	School: Elem Jr/Sr Other	Grade Level:
	Date Reg complete: Initials:	___ IEP ___ 504 ___ ELL ___ AIS	
	DOB verified Date: Initials:	Residency verified with:	Initials:

Cato-Meridian Central School District
STUDENT REGISTRATION FORM

Student Name _____ Grade _____
LAST FIRST MIDDLE GENDER

Date of Birth ____ / ____ / _____ Age ____ Home Phone: _____

Residence Address: _____
STREET ADDRESS CITY STATE ZIP

Mailing Address (if different from Residence Address): _____
PO BOX # CITY STATE ZIP

ADULTS IN HOUSEHOLD

Primary Contact Name:
Relationship to Student:
Email address:
Employer:
Work Phone:
Cell Phone:

Secondary Contact Name:
Relationship to Student:
Email address:
Employer:
Work Phone:
Cell Phone:

CUSTODY INFORMATION

Who does the student live with?

- Both parents
 Father *
 Mother *
 Legal Guardian *

* Court ordered custody paperwork **must** be submitted at time of registration.

TRANSPORTATION

Will your student need transportation? Yes No

LIST OTHER CHILDREN IN YOUR HOUSEHOLD

Name	DOB	Age	Gender	Relationship

EMERGENCY CONTACTS (by listing a contact here, you are giving them permission to pick up your student)

Contact 1:
Cell Phone:
Relationship to Student:

Contact 2:
Cell Phone:
Relationship to Student:

FOSTER AGENCY Not applicable

Agency Name: _____

Caseworker: _____

HEALTH INFORMATION

Family Doctor Name: _____ Phone: _____

In an emergency, do we have your permission to call the nearest doctor? Yes No

In an emergency, which hospital do you prefer?: _____

If you are aware of a health factor which may have a bearing on your child's classroom behavior, check below.

Vision Speech Hearing Emotional Instability Other _____

TRANSFER INFORMATION Not applicable

Name of Previous School District: _____

Name of Previous School: _____

City: _____ State: _____ Phone: _____ Fax: _____

Special Education Services currently in place:

- 504 Accommodation plan
- IEP
- Other: _____

Has the student previously attended the Cato-Meridian Central School District?

- Yes Year last attended: _____
- No

INFORMATION WAIVER

The following statement indicates your permission for the exchange of those records which would be helpful to the education of your child. I hereby consent to the giving or receiving of the student records of my child including health, psychological and academic between the Cato-Meridian Central School District and other school districts or any duly constituted agencies or specialists.

Student Name (print) _____

Parent Name (print) _____

Parent Signature _____

Date: _____

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

Housing Questionnaire

Name of LEA: Elizabeth Kupiec

Name of School: Cato-Meridian Central School District

Name of Student: _____

Gender	Date of Birth: ____ / ____ / ____	Grade:
<input type="checkbox"/> Male	Address:	
<input type="checkbox"/> Female	Phone number:	

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, immunizations, or birth certificates. 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 member 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, Legal guardian or Student (for unaccompanied homeless youth)	Signature of Parent, Legal Guardian, or Student (for unaccompanied homeless youth)	Date
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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 immunizations.

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

CALL ORDER

Please indicate below the order in which contacts should be called regarding school matters:

Rank	Name	Phone number
1.		
2.		
3.		
4.		
5.		
6.		

NON-CUSTODIAL PARENT INFORMATION Not applicable

Non-custodial parents are allowed (unless directed by the courts) to have access to their child's academic records. Please add that information below, if that parent is not already listed as an emergency contact.

Name:		
Relationship to the student:		
Mailing address:		
Email address:		
Phone number:	Is this parent allowed to pick up student?	Y N



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.

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

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? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

Date

Relationship to student: Parent 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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
 MO. DAY YR. ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

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

Student Racial and Ethnic Identification

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

Student Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Grade: _____

Directions to Parent/Guardian: Please read and answer questions (1) and (2).

For question (1), please check (x) the box that best describes your child. Check (x) 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

For question (2), please check (x) ALL groups that apply to your child. Check (x) at least ONE box.

2. Which one or more of the races from the following five (5) racial groups represents the student?

- 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 Phillipine Islands, Thailan, and Vietnam.
- Native Hawaiian or other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- 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.

(Signature of Parent/Guardian)

(Date)

(Relationship to the student)

Student Health History
Cato-Meridian Central Schools

Student Name:	Birthday:	Grade:
Individual providing health history:		

History:

Were there any issues during pregnancy, labor and/or delivery for this child?

<input type="checkbox"/> Yes please describe: _____	<input type="checkbox"/> No
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Does this child have an ongoing health concern? (asthma, diabetes, seizures, etc)

<input type="checkbox"/> Yes please describe: _____	<input type="checkbox"/> No
--	-----------------------------

Does this child have any allergies? (medicine, food, environmental, insect)

<input type="checkbox"/> Yes please list: _____	<input type="checkbox"/> No
--	-----------------------------

Has the allergy required emergency treatment?

<input type="checkbox"/> Yes please explain: _____	<input type="checkbox"/> No
---	-----------------------------

Are the child's immunizations up to date?

<input type="checkbox"/> Yes	<input type="checkbox"/> No Additional immunizations required: _____
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Is there a history of any hospitalizations, significant injuries or surgery?

<input type="checkbox"/> Yes please explain: _____	<input type="checkbox"/> No
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Are there any current medical concerns/injuries?

- Yes
- No

If yes, please indicate type below:

<input type="checkbox"/> Head: _____	<input type="checkbox"/> Eyes: _____	<input type="checkbox"/> Nose: _____
<input type="checkbox"/> Ears: _____	<input type="checkbox"/> Throat: _____	<input type="checkbox"/> Neck: _____
<input type="checkbox"/> Chest: _____	<input type="checkbox"/> Respiratory: _____	<input type="checkbox"/> Cardiovascular: _____
<input type="checkbox"/> Gastrointestinal: _____	<input type="checkbox"/> Genitourinary: _____	<input type="checkbox"/> Neurological: _____
<input type="checkbox"/> Musculoskeletal: _____	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Other: _____

Does this child take any medication regularly at home?

<input type="checkbox"/> Yes please list: _____	<input type="checkbox"/> No
--	-----------------------------

Does this child require any medication at school?

<input type="checkbox"/> Yes please list: _____	<input type="checkbox"/> No
--	-----------------------------

- *A doctor's prescription, your permission, and a labeled pharmacy container with medication is required for medication to be given at school. Please see the School Nurse for paperwork.*

List any significant medical concerns in the family:

<input type="checkbox"/> Mother: _____	<input type="checkbox"/> Father: _____
<input type="checkbox"/> Siblings: _____	<input type="checkbox"/> Grandparents: _____
<input type="checkbox"/> Other: _____	

In the event of a medical emergency, which hospital do you prefer your child to be transported to?

May we contact the nearest doctor in an emergency as well?

- Yes
- No

PLEASE INCLUDE ANY ADDITIONAL OR PERTINENT INFORMATION BELOW

Dr. Terry Ward
Superintendent of Schools

Mrs. Danielle Mahoney
Elementary Principal

If your child(ren) in Grades 1-6 are to be picked up or dropped off at a location, **even home**, PLEASE fill this form out and return it to the Elementary Office by August 15. **All UPK and K** students are asked to fill out this form (home and other locations). 😊

BUS REQUEST FORM FOR UPK-6 STUDENTS

Permanent Weekly Transportation Schedule

(If this information changes throughout the school year, it is your responsibility to fill out a new form.)

Please fill out a separate form for **EACH** child. A new form is to be completed each year.

Student Name: _____ Grade: _____
 Parent Name: _____ Teacher Name: _____
 Home Address: _____ Telephone #'s: (home) _____
 Home Bus Number (If known): _____ (work) _____
 (cell) _____

Please note: Daily bus passes are accepted for emergencies only. Please strive for consistency and safety.

<p><u>EVERY MONDAY</u></p> <p>A.M. Pick-Up Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY TUESDAY</u></p> <p>A.M. Pick-Up Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY WEDNESDAY</u></p> <p>A.M. Pick-Up Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY THURSDAY</u></p> <p>A.M. Pick-Up Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY FRIDAY</u></p> <p>A.M. Pick-Up Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>
<p><u>EVERY MONDAY</u></p> <p>P.M. Drop-Off Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY TUESDAY</u></p> <p>P.M. Drop-Off Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY WEDNESDAY</u></p> <p>P.M. Drop-Off Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY THURSDAY</u></p> <p>P.M. Drop-Off Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>	<p><u>EVERY FRIDAY</u></p> <p>P.M. Drop-Off Bus #: _____ Name/Location: _____ _____ _____ Phone: _____</p>

Effective Date: _____ Parent Signature: _____ Today's Date: _____