MIDDLEBURGH CENTRAL SCHOOL DISTRICT

Registration Packet Includes:

- Request for Student Records
- Registration Form
- Educational History
- Child Development & Medical History
- NYS Health Examination Form
- Dental Health Certificate
- Proof of Residency/Housing
- Home Language Questionnaire
- Technology Use Forms/Handbook
  - Student Acknowledgement Form
  - Parent/Guardian Acknowledgement Form
  - Acceptable Use Policy Form
- Student Handbook & Signature Page
- Transportation Form
- Application for Free/Reduced School Meals

In order to complete registration (this includes UPK programs) the following documents must be provided:

☐ Parent/Legal Guardian Photo ID
  ☐ Valid State Issued ID or Valid Passport

☐ Proof of Residency
  ☐ Must provide TWO acceptable forms of proof:

    ☐ Utility bill, official payroll document or letter from a federal, state or local government agency, current property tax bill, copy of signed lease agreement

☐ Birth Certificate
  ☐ Original (we will make a copy) or Certified Copy or Valid Passport

☐ Proof of Immunization
  ☐ Must be signed or stamped by a state licensed health care provider

☐ Custody Papers (if Applicable)

☐ Special Circumstances (Residency Questionnaire)

  ☐ If applicable, detailing legal guardianship situations, temporary living situations, custody agreements, name changes

MIDDLEBURGH CENTRAL SCHOOL DISTRICT

Request for Student Records

(Previous School District)

_____
_____
_____

Please be advised that the following student, previously enrolled in your school, has transferred to the Middleburgh Central School District.

I hereby authorize the following information to be sent to the school indicated below.

Student's Name (First, Middle, Last)	Gender	Date of Birth	Grade Level:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Requested Records:

- Academic Transcripts/Report Card
- Individualized Education Plans
- 504 Plans
- Health and Immunizations
- State Test Scores
- Standardized Test Scores
- Regents and RCT Scores
- Functional Behavioral Assessments
- Social Work
- Record of Birth
- Discipline
- Other pertinent information to ensure proper placement

Please Fax the information requested to:

Laurie McGeary
Email: Laurie.McGeary@mcsdny.org
Phone: (518)827-3600 Ext. 2601
Fax: (518)827-5181

Parent/Guardian Signature: _____ **Date:** _____

Middleburgh Central School District

Registration Form

Please Choose the appropriate program according to date of birth:*

☐ 3 Year Old UPK (3 by12/1) AM / PM ☐ 4 Year Old UPI<(4 by12/1) AM / PM
☐ Kindergarten (5 by12/1) ☐ *My child will be attending AM Head start
☐ Grade

Student's Name: _____ Middle Initial: ___ Last Name: _____

Gender: ____ Date of Birth: _____ Primary Language: _____

Is Hispanic? (Optional) ☐Yes ☐No

Race (Optional): ☐White ☐Black or African American ☐Asian ☐American Indian or Alaskan Native

☐Native Hawaiian/Other Pacific Islander

Mailing Address: _____
Physical Address: _____
Student's Home Phone: _____Student's Cell Phone: _____

Parent/Guardian Information:

Student resides with: ☐Parents ☐Mother ☐Father ☐Foster Parents *(please see attached form DSS-299)* ☐

Other Are there Legal Arrangements: ☐No ☐Yes *If yes, please provide court documents*

☐Joint Custody ☐Sole Custody ☐Temporary Custody ☐Visitation

Primary Parent/Guardian Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Workplace:_____ Work Phone: _____

Choose All that Apply to above person:

Receives Mail ☐Can Pick Up ☐Custody Alert ☐Allow Parent Portal Access ☐ Restricted

Primary Parent/Guardian Name:_____ Relationship to Child: _____

Home Phone: _____Cell Phone: _____

Email Address:_____

Work Place: _____ Work Phone: _____

Choose All that Apply to above person:

☐Receives Mail ☐Can Pick Up ☐Custody Alert ☐Allow Parent Portal Access ☐Restricted

List all Siblings that live in household	**Gender**	**Birthdate**	**Grade**	**School**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

*Please note preferences for am or pm does not guarantee placement. Final placement will be determined by district and you will be informed by mail of your child's placement.

Middleburgh Central School District

Educational History

Student Name:_____

Has the student previously attended School in the Middleburgh Central School District?

☐Yes ☐No If Yes, which school: _____

Does the student have an IEP (Individual Education Plan)?

☐Yes ☐No

Does the student have a 504 Plan?

☐Yes ☐No

Has the student participated in any of the following programs? *Check all that apply*

☐Academic Intervention Service ☐Reading Services

☐Math Services ☐Other: _____

Please Check any special programs that your child has been assigned to in the past:

☐Consultant Services	☐Resource Room	☐Bilingual Education
☐Special Classes	☐Occupational Therapy	☐Speech Therapy
☐Physical Therapy	☐Counseling	☐Other:

UPK Parents Only:

Did your child attend: ☐UPK-3 Location: _____

☐Head Start Location: _____

Please list all previous schools beginning with most recent:

Name of School: _____
Address: _____
Phone: _____

Name of School: _____
Address: _____
Phone: _____

Name of School: _____
Address: _____
Phone: _____

Child Developmental & Medical History

Student's Name:	Grade: M/F Date of Birth:
Birth:	Developmental:
Term: Weight:	First Tooth Age: Sat Alone Age:
Delivery:	Crawled Age: Walked Age:
Conditions:	Talked at Age:
Abnormalities:	

1. Were problems experienced during pregnancy which required medical intervention? If yes, what were they:
2. Were there any complications at birth? (premature, *prolonged labor, need for oxygen, difficult delivery):*
3. Please note any congenital conditions present at birth:
4. Did your child proceed through developmental stages normally?
5. Were there any particular difficulties as a preschooler? *(Difficulty watering, sleeping, bedwetting, etc)*
6. Any diseases, illnesses, or injuries which required medical attention?
7. Any undiagnosed illnesses? *(Prolonged high fever, convulsions, seizures, etc.)*
8. Any hospitalizations? If so, for what reason?
9. Has your child had surgery for any reason? If yes, when and for what?
10. Have hearing or visual aides ever been required for your child? If yes, when and what for?
11. Has your child been on medication for any reason?
12. Have there been any neurological problems diagnosed on your child, birth to present? If so, please explain:
13. Attention problems or hyperactivity problems? Has medication been prescribed? If yes, what med and when started? _____
14. Previous or current cancer treatments? Please explain:
15. Please explain any other pertinent medical, dental or psychological history:
16. Is your child a twin? If yes, birth order: Twin 1 _____ Twin 2: _____

Child Developmental & Medical History

Has your child had the following? (Please check and list date(s)):

Illness		*Date*	*Illness*		*Date*
Chicken Pox	☐	_____	Diabetes	☐	_____
Scarlet Fever	☐	_____	Hepatitis	☐	_____
Pneumonia	☐	_____	Seizures (List Type)	☐	_____
Bronchitis	☐	_____	Asthma	☐	_____
Breathing Difficulties	☐	_____	Allergy to bee stings	☐	_____
Blood Disorders	☐	_____	Family history of bee allergy**	☐	_____
Rheumatic Fever	☐	_____	Frequent Ear Infections/Aches	☐	_____
Kidney Problems	☐	_____	Frequent Colds	☐	_____
Tuberculosis	☐	_____	Frequent Strep Throat	☐	_____
Family History of TB	☐	_____	Ear Condition	☐	_____
Contact with TB	☐	_____	Ear Tubes	☐	_____
Heart Disease	☐	_____	Vision Difficulties	☐	_____
Heart Murmur	☐	_____	Cataracts	☐	_____
Scoliosis	☐	_____	Speech Difficulties	☐	_____
Frequent Nosebleeds	☐	_____	Emotional Problems	☐	_____
Food Allergies (Please List)	☐	_____	Behavioral Problems	☐	_____
Lactose Intolerant	☐	_____	Frequent Headaches	☐	_____
other	☐	_____	Epilepsy	☐	_____

**Type of reaction to Bee Sting:

Regarding Allergies:

Does your child have allergies: ☐Yes ☐No If yes, what allergies? _____

Does your child require medication for allergies? ☐Yes ☐No If yes, what medication?_____

Does your child require medication to stay in school? ☐Yes ☐No If yes, what medication? _____

Please note: regarding medications in school, both a signed doctor's note and a parent note are required in order for the school nurse to administer medications.

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone:_____

Parent Signature: _____ **Date:** _____

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: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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/m2

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

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

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

Vision	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

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.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

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.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Middleburgh Central School District

Proof of Residency/Housing

Name of Student:_____

If registering more than one student, you can list them below.

Student:	Gender:	Date of Birth:	Grade:

Please check one: ☐Own ☐Reside with a district resident ☐Rent ☐Temporary living situation

To enroll you must reside within the district. Solely owning property or a home does not constitute residency. Proof of residency is required before a student may be registered. Post office boxes will not be accepted. You must provide at least two (2) proofs from the following list:

If you own:	***If you rent:***
☐ Tax Bill within 30 days	☐ Documents issued by the federal, state or local agencies
☐House Deed	☐ Lease agreement *(must be signed with the landlord's* name *and* phone *number)*
☐Mortgage Statement within 30 days	☐Current Renter's Insurance
☐ Current Homeowner's Insurance	
☐ Utility Bill within 30 days	
☐ Voter Registration	

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 *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?
☐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

This document will be retained in the student's file along with other required documents. Once this form is received by the District Registrar, residency will be verified.

Parent/Guardian Signature:_____ Please Print Name:_____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

Office of P12

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:

Month *Day* *Year*

GENDER:

❑ Male
❑ 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?	❑ English	❑ Other:	
2. What was the first language your child learned?	❑ English	❑ Other:	
3. What is the Home Language of each parent/guardian?	❑ Parent 1	_____ *specify*	❑ Parent 2 _____ *specify*
	❑ Guardian(s)	_____ *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other:	
5. What language(s) does your child speak?	❑ English	❑ Other:	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other:	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other:	❑ Does not write

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:*	

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

Relationship 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: ❑ YES ❑ NO

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

OFFICE USE ONLY
Date Received: _____
Date Approved: _____

Middleburgh Central School District
Transportation Department
Alternate Transportation/Emergency Closing Form/Parent Transportation

School Year:_____ Effective Date:_____

I am requesting transportation for my child/children to the location below:

Child's Name	School Building	Grade/Teacher

Please transport my child/children to:
Home Address: _____
Home Phone: _____

Alternate Location

_____ Home/Legal Residence Bus Number

_____ Number Alternate Location Bus Number

Check All that Apply:

Monday	**AM Only**	**PM Only**	**AM/PM**	As Needed
Tuesday	**AM Only**	**PM Only**	**AM/PM**	As Needed
Wednesday	**AM Only**	**PM Only**	**AM/PM**	As Needed
Thursday	**AM Only**	**PM Only**	**AM/PM**	As Needed
Friday	**AM Only**	**PM Only**	**AM/PM**	As Needed

IF ALTERNATE LOCATION IS NOT USED ON A CONSISTENT BASIS, THEN A BUS NOTE MUST BE SUBMITTED EVERY TIME THE ALTERNATE ROUTE WILL BE USED

PARENT TRANSPORT: Student(s) will not need district provided transportation for the _____School Year:

☐ Parent Transport

_____ _____
Parent/Guardian Print Name Home Phone

_____ _____
Physical Address Emergency Phone

_____ _____
Parent/Guardian Signature Date

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)

☐ Work related to logging, harvesting, or initial processing of trees.

☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

MIDDLEBURGH SCHOOL CENTRAL DISTRICT
STUDENT ACCEPTABLE USE POLICY & ACKNOWLEDGMENT FORM

In consideration for the use of the Middleburgh School District's Computer System (DCS), I agree that I have been provided with a copy of the District's policy on student use of computerized information resources and the regulations established in connection with that policy. I agree to adhere to the policy and the regulations and to any changes or additions later adopted by the District. I also agree to adhere to related policies published in the Student Handbook.

I understand that failure to comply with these policies and regulations may result in the loss of my access to the DCS. Prior to suspension or revocation of access to the DCS, students will be afforded applicable due process rights. Violation of District policy and regulations may also result in the imposition of discipline under the District's school conduct and discipline policy and the *Code of Conduct*. I further understand that the District reserves the right to pursue legal action against me if I willfully, maliciously, or unlawfully damage or destroy property of the District. Further, the District may bring suit in civil court in accordance with General Obligations Law Section 3-112 against my parents or guardians if I willfully, maliciously, or unlawfully damage or destroy District property.

I hereby acknowledge and accept full responsibility, including damage/loss/theft, for this Dell Latitude 3100 Chromebook and power cord for the duration of the student's enrollment in Middleburgh Central School District.

This device is only for the student use with the "MCSDNY.org" district-provided Google account. As such, content accessed with this device is **always** filtered using *Lightspeed Systems* for inappropriate material and uses not meant for educational purposes.

Data Privacy and Security Considerations for Families:

By signing below, I am acknowledging that I have read and will comply with the *Middleburgh Central Technology Use Agreement Handbook and School District Acceptable Use Policy (BOE Policy - 7316.*

Device: One (1) Dell Latitude 3100 Chromebook and One (1) Charge

Service Asset Tag/Serial#: _____

Print Student Name: _____

Student Signature: _____

Student ID#: _____

Student Grade Level: _____

Date: _____

Middleburgh 1:1 Computer Consent Form

I am the parent or guardian of ,
the minor student who has signed the District's agreement for student use of computerized information resources. I have been provided with a copy and I have read the District's policy and regulations concerning use of the DCS.

I also acknowledge receiving notice that, unlike most traditional instructional or library media materials, the DCS will potentially allow my child student access to external computer networks not controlled by the Middleburgh School District. I understand that some of the materials available through these external computer networks may be inappropriate and objectionable; however, I acknowledge that it is impossible for the District to screen or review all of the available materials. I accept responsibility to set and convey standards for appropriate and acceptable use of technology to my son or daughter when he or she is using the DCS or any other electronic media or communications, including my son or daughter's own personal technology or electronic device on school grounds or at school events.

I agree to release the Middleburgh School District, the Board of Education, its agents and employees from any and all claims of any nature arising from my son or daughter's use of the DCS in any manner whatsoever.

I agree that my child will have access to the DCS and I agree that this may include remote access from our home.

Parent/Guardian: Acknowledgment

By accepting this device from the Middleburgh Central School District, you are agreeing to the terms in this agreement. You acknowledge that you have read and will comply with the *Middleburgh Central School District Technology Use Agreement Handbook and School District Acceptable Use Policy (BOE Policy - 7316).*

These are the estimated costs of the most common repairs:

- Broken screen $250
- Cracked case (laptop body) $75
- Replacement keyboard $75
- Broken or lost charger $35
- Broken AC adapter port $30
- Device replacement $475

The Middleburgh Central School District is sponsoring an optional Device Service Plan for a fee of $20 per school year. Coverage includes:

- First Claim: Free of charge service with optional Device Service Plan
    - What is covered: One accidental damage of the device if the cost to fix the damage is lessthan $75, or $75 deducted from the bill if the repair costs more.
- Additional Claims: User is responsible for the full cost of the repairs or replacement.

Payments for the Device Service Plan can be made via check or cash - payable to: Middleburgh Central School District.

In the event of theft, a claim must be accompanied by a Police Report for a new device to be replaced.

Device Borrowing Terms

Students must return their device at the end of each academic year for inspection, software updates and maintenance. The same device will be issued back to the student at the start of the next school year.

Students are not to add unauthorized programs, apps or software not approved by the Middleburgh Central School District.

Students are **not** to remove the device asset tag.

To Report a Claim or Damage:

Bring your device to the Library Media Center to have an IT Ticket submitted. If you device is lost, report it to Jody DeJong in the Library Media Center

Payments/Lost/Broken Devices

Bills for repairs are sent out monthly during the school year, and in July for the end of the school year. Payments for repair/replacement can be made via check or cash - payable to *Middleburgh Central School District*.

Print Parent/Legal Guardian Name: _____

Print Student Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

Middleburgh Junior-Senior High School
2024-2025

SIGNATURE PAGE

(Please complete and return)

STUDENT HANDBOOK By checking this box and signing below, both the parent/legal guardian and the student acknowledge they have read, discussed and understand the contents of the 24-25 Middleburgh Student Handbook.
https://www.middleburghcsd.org/about-us/middleburgh-junior-senior-high-school-student-handbook-2024-2025/

GOOGLE WORKSPACE FOR EDUCATION PERMISSION By checking this box you are acknowledging the use of Google platforms that are outside of the general education products. This includes Google Maps, Google Earth, Google Photos, Google Books, Extensions from the Chrome Web Store and Youtube.

ATTENDANCE POLICY By checking this box and signing below, both the parent/legal guardian and the student acknowledge that the Attendance Policy has been read and understood.

CELL PHONE POLICY By checking this box I understand that cell phones are not to be used during the school day, except during your designated lunch period. Consequences will be given if this policy is not followed.

I have read and acknowledged the permissions and policies for the 2024-2025 school year.

Print name of student: _____

Signature of student: _____

Print name of parent: _____

Signature of parent: _____

Date: _____