

# HUDSON FALLS CENTRAL SCHOOL DISTRICT

## PART 1: ENROLLMENT/REGISTRATION REQUIREMENTS

Student Name: \_\_\_\_\_

\_\_\_\_\_ SIGNED RESIDENCY QUESTIONNAIRE

\_\_\_\_\_ COMPLETED AND SIGNED REGISTRATION FORM

\_\_\_\_\_ PROOF OF RESIDENCY

- LEASE AGREEMENT OR NOTORIZED STATEMENT FROM LANDLORD THAT INCLUDES THE FULL ADDRESS OF YOUR RESIDENCE
- COPY OF PURCHASE CONTRACT FOR THE RESIDENCE YOU WILL BE LIVING IN, WITH LETTER FROM ATTORNEY THAT INCLUDES DATE/TIME OF CLOSING
- NOTORIZED STATEMENT FROM A THIRD PARTY ESTABLISHING THE PHYSICAL PRESENCE OF THE PARENT/GUARDIAN IN THEIR HOUSEHOLD IN THE SCHOOL DISTRICT
- COPY OF DEED

### ACCEPTED ALTERNATE FORMS OF RESIDENCY IF THE ABOVE ARE UNAVAILABLE

- PAY STUB
- INCOME TAX FORM
- UTILITY BILL
- OFFICIAL DRIVER'S LICENSE, LEARNER'S PERMIT, OR NON DRIVER ID
- STATE OR OTHER GOVERNMENT ISSUED ID
- DOCUMENTS ISSUED BY FEDERAL, STATE OR OTHER LOCAL AGENCIES

\_\_\_\_\_ BIRTH CERTIFICATE      BAPTISMAL RECORD      PASSPORT

### ACCEPTED ALTERNATE FORMS IF THE ABOVE ARE NOT AVAILABLE

- OFFICIAL DRIVERS LICENSE OF STUDENT ( if applicable)
- SCHOOL PHOTO ID WITH DATE OF BIRTH
- CONSULATE ID CARD WITH DATE OF BIRTH
- MILITARY DEPENDENT ID WITH DATE OF BIRTH
- NATIVE AMERICAN TRIBAL DOCUMENTS WITH DATE OF BIRTH

\_\_\_\_\_ COURT CUSTODY PAPERS or CUSTODIAL AFFADAVITS (if applicable)

\_\_\_\_\_ REQUEST FOR RELEASE OF RECORDS COMPLETED AND SIGNED



**HUDSON FALLS CENTRAL SCHOOL DISTRICT**  
**PO Box 710**  
**Hudson Falls, NY 12839**  
**(518) 747-2121**

**REQUEST FOR RELEASE OF STUDENT RECORDS**

To: \_\_\_\_\_  
Previous School Name \_\_\_\_\_ Student Name \_\_\_\_\_

\_\_\_\_\_  
Street Address of Previous School \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_ School Fax # \_\_\_\_\_ School Phone # \_\_\_\_\_

The above student has registered for grade \_\_\_\_\_ at our school district. Please forward, at your earliest convenience, the following school records:

- Academic Record
- Attendance Record
- Health/Immunization Record
- Standardized Test Data
- Approx. grades for the current marking period
- CSE Records (IEP, Social History, Psycho-educational Evaluation, Speech Evaluation, OT/PT Scripts, Medical Records, Medicaid Consent Form)

\*It is understood that the privilege and confidential nature of such records will be preserved.

These records should be sent to the following indicated address:

Margaret Murphy Kindergarten Center  
2 Clark Street  
Hudson Falls, NY 12839  
Fax: (518) 747-3853  
Phone: (518) 681-4512

Hudson Falls Intermediate School  
139 Maple Street  
Hudson Falls, NY 12839  
Fax: (518) 747-2774  
Phone: (518) 681-4400

Hudson Falls Middle School  
131 Notre Dame Street  
Hudson Falls, NY 12839  
Fax: (518) 746-2790  
Phone: (518) 681-4319

Hudson Falls Primary School  
47 Vaughn Road  
Hudson Falls, NY 12839  
Fax: (518) 747-3502  
Phone: (518) 681-4462

Hudson Falls Senior High School  
Guidance Dept.  
80 East LaBarge Street  
Hudson Falls, NY 12839  
Fax: (518) 746-9033  
Phone: (518) 681-4214

Hudson Falls District Office  
80 East LaBarge St.  
Hudson Falls, NY 12839  
Fax: (518) 681-4136  
Phone: (518) 747-2121

I hereby request and direct the above school to release and/or exchange all information pertaining to the above student.

\_\_\_\_\_  
Date

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

Updated 10/19/16

\_\_\_\_\_  
Relationship



# HUDSON FALLS CENTRAL SCHOOL DISTRICT

## Student Registration Form

Office Personnel Please Sign & Enter - DATE OF REGISTRATION:

Complete all information carefully. Please print.

GRADE ENTERING: \_\_\_\_\_

STUDENT'S LEGAL NAME: \_\_\_\_\_  
(First) (Middle) (Last)

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_ GENDER: ☐ Male ☐ Female

STREET ADDRESS: \_\_\_\_\_ MAIN CONTACT # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Address where Student resides ) ( No P.O. Boxes ) (APT. OR LOT #)  
\_\_\_\_\_, NY \_\_\_\_\_  
City Zip

MAILING ADDRESS: \_\_\_\_\_  
(If different from Street Address)  
\_\_\_\_\_, NY \_\_\_\_\_  
City Zip

FAMILY INFORMATION - Student lives with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Mother/Stepfather  
☐ Father/Stepmother ☐ Grandparents ☐ Self ☐ Guardian(s) \_\_\_\_\_ (First & Last Name)  
☐ Other \_\_\_\_\_ ☐ Foster Parent(s) \_\_\_\_\_ (First & Last Name)

\* Court documents or Custodial /Non-Custodial affidavits stating current custody arrangements must be provided to the school district if student is not living with both parents. \*\* If a foster placement, a copy of DSS 2999 form must be submitted.

FATHER: \_\_\_\_\_ MAIN CONTACT # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_ Work Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Step Parent \_\_\_\_\_ Cell Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ \*Only complete if different than Student Mailing Address \_\_\_\_\_  
(if different )

MOTHER: \_\_\_\_\_ MAIN CONTACT # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_ Work Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Step Parent \_\_\_\_\_ Cell Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ \*Only complete if different than Student Mailing Address \_\_\_\_\_  
(if different )

BROTHERS AND SISTERS: (living in same household that are expected to attend one of the schools in our district )

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_ ☐ Male ☐ Female

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_ ☐ Male ☐ Female

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_ ☐ Male ☐ Female

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_ ☐ Male ☐ Female

OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

Student ID#: \_\_\_\_\_ Date Entering: \_\_\_\_\_ Homeroom: \_\_\_\_\_ Birth Certificate: Yes / No Custody Papers Rec'd: Yes / No

HAS YOUR STUDENT EVER BEEN REGISTERED IN THE HUDSON FALLS SCHOOL DISTRICT : YES / NO (circle one)

**PREVIOUS SCHOOL INFORMATION:** Name of School Last Attended \_\_\_\_\_

School Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ School Fax Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\* Has your child ever repeated a grade? Yes No (Circle One) If yes, which grade: \_\_\_\_\_

For High School Students, what date did they enter into 9<sup>th</sup> grade? \_\_\_\_\_

**\* SPECIAL NEEDS OF THE STUDENT**

Does your child currently receive free or reduced lunch? No Free Reduced (Please Circle One)

Does the student receive AIS? Yes No (Please Circle One) If Yes, what subject? \_\_\_\_\_

\* Does the student receive Special Education services? Yes No (Circle One)

If Yes, does he/she currently participate in any of the following: (circle any that apply) IEP - Self Contained Classroom - Consultant Teacher - Resource Room - Speech/Language Therapy - Occupational Therapy - Physical Therapy - 504 Plan - BOCES Placement. Other special needs \_\_\_\_\_

Medicaid Health Care Plan # \_\_\_\_\_

**\* EMERGENCY CONTACT PERSON(s):** When injury, illness or non-emergency situations occur involving your child, we want to be able to quickly reach families and other responsible adults. In the event that we cannot reach a parent/guardian, please list a person you trust who is available during the day to provide care for your child. (Must be a local contact)

Full Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Full Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Full Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Full Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Parent/Guardian or Eligible Student Statement:** I certify that the above information is true and correct. Any misinformation regarding residency or custody may result in being billed to cover the cost of instruction and/or exclusion from attending the Hudson Falls Central School District. I further understand that it is my responsibility as the Parent/Guardian or Eligible Student to immediately inform the school district of any changes in the information provided.

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# HUDSON FALLS CENTRAL SCHOOL DISTRICT

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## **PART 2: ENROLLMENT/REGISTRATION REQUIREMENTS**

*Grades 1-12*

PLEASE BE PREPARED TO SUBMIT THE FOLLOWING ADDITIONAL REQUIREMENTS AFTER STUDENT IS ENROLLED
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Student Name: \_\_\_\_\_

- \_\_\_\_ HQL: HOME LANGUAGE QUESTIONNAIRE
- \_\_\_\_ STUDENT RACIAL / ETHNIC IDENTIFICATION FORM
- \_\_\_\_ TRANSPORTATION / SITTER FORM
- \_\_\_\_ PESTICIDE APPLICATION
- \_\_\_\_ STUDENT QUESTIONNAIRE
- \_\_\_\_ IMMUNIZATION RECORDS
- \_\_\_\_ RECENT HEALTH APPRAISAL / PHYSICAL
- \_\_\_\_ COMPLETED CUMULATIVE HEALTH RECORD
- \_\_\_\_ DENTAL HEALTH CERTIFICATE (UPK – 5TH grade)
- \_\_\_\_ CHROMEBOOK USER AGREEMENT (grades 6-12)
- \_\_\_\_ ATHELETIC PARTICIPATION REGISTRATION FORM (High School only)
- \_\_\_\_ HFCSD SPORTS PARENTAL APPROVAL FORM (High School & Middle School)

# HUDSON FALLS CENTRAL SCHOOL DISTRICT

## Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

### To Be Completed By School Personnel

District: Hudson Falls Central School District School: \_\_\_\_\_

Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ ID# \_\_\_\_\_

Country of Birth: \_\_\_\_\_

Number of years enrolled in school outside the US: \_\_\_\_\_

Name/Position of School Personnel Completing This Section:

\_\_\_\_\_

Determination: \_\_\_\_\_ Possible LEP \_\_\_\_\_ English Proficient

(Circle all that apply)

1. What language(s) is spoken in the student's home or residence? English Spanish Other \_\_\_\_\_ Specify
2. What language(s) are spoken most of the time to the student, in the home or residence? English Spanish Other \_\_\_\_\_ Specify
3. What language(s) does the student understand? English Spanish Other \_\_\_\_\_ Specify
4. What language(s) does the student speak? English Spanish Other \_\_\_\_\_ Specify
5. What language(s) does the student read? English Spanish Other \_\_\_\_\_ Specify
6. What language(s) does the student write? English Spanish Other \_\_\_\_\_ Specify

7. In your opinion, how well does the student understand, speak, read and write English?

(Please circle one)

Understands English:	Very Well	Only a little	Not at all
Speaks English:	Very Well	Only a little	Not at all
Reads English:	Very Well	Only a little	Not at all
Writes English:	Very Well	Only a little	Not at all

\_\_\_\_\_  
Signature of Parent/Guardian/Other

\_\_\_\_\_  
Date

# Hudson Falls Central School District

## Student Racial and Ethnic Identification

Student Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle mm/dd/yyyy

**Directions to Parent/Guardian:** PLEASE ANSWER BOTH QUESTIONS BELOW. PLEASE READ THEM BEFORE YOU RESPOND.

FOR QUESTION (1) **CHECK ONLY ONE** RESPONSE THAT BEST DESCRIBES YOUR CHILD.

FOR QUESTION (2) CHECK ALL GROUPS THAT APPLY TO YOUR CHILD. **Check at least ONE choice.**

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

2. Select one or more races from the following five racial groups.

\_\_\_\_\_ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. (For example: Cherokee, Mohawk, Inuit, etc.)

\_\_\_\_\_ **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 Philippine Islands, Thailand, 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:** 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/Other

\_\_\_\_\_  
Date

Relationship to Student (Please circle one): Mother Father Guardian Other (Specify) \_\_\_\_\_

This form will become part of your child's permanent record. The information you provide on this form is confidential and it is protected by the Confidentiality Regulations cited here: "The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number."

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



Hudson Falls Central School  
Transportation Information Form  
Hudson Falls School District Policy

1. Students who are in Pre-K or Kindergarten **MUST** be met by an Adult, if nobody is there to meet the student, they will be taken back to school.
2. Transportation Information Form must be filled out for each school year, even if the information is the same as the previous year.
3. Transportation Information Forms are available at each school and/or the Transportation Department.

**NOTE: REQUEST FORM MUST BE FILLED OUT PRIOR TO CHANGE AND PLEASE PLAN FOR CHANGES TO TAKE A MINIMUM OF ONE WEEK TO PROCESS!**

Today's Date \_\_\_\_\_ Effective Date: \_\_\_\_\_

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

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

Primary Home Address: \_\_\_\_\_

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

AM Sitter/Child Care Provider : \_\_\_\_\_

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

Sitter Home Phone: \_\_\_\_\_ Sitter Cell Phone: \_\_\_\_\_

Please *circle* which days your child will be PICKED UP at daycare:

MON          TUES          WED          THURS          FRI

PM Sitter/Child Care Provider : \_\_\_\_\_

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

Sitter Home Phone: \_\_\_\_\_ Sitter Cell Phone: \_\_\_\_\_

Please *circle* which days your child will be DROPPED OFF to daycare:

MON          TUES          WED          THURS          FRI

Parent/Guardian Signature \_\_\_\_\_

Please mail to: Hudson Falls Central School  
Transportation Department  
3663 Burgoyne Avenue  
Hudson Falls, NY 12839  
FAX 518-747-9179

**ANNUAL NOTIFICATION  
of the Availability of  
The District Asbestos Management Plan  
2020-21 School Year**

**DATE:** August 10, 2020

**DISTRICT:** Hudson Falls Central School

**ADDRESS:** PO Box 710, Hudson Falls, NY 12839

**SUBJECT:** Asbestos Management Plan - Annual Notification

The **Hudson Falls Central School District** will submit in **2020** information about the asbestos materials in the district's buildings to the New York State Education Department. This information, the school district's Asbestos Management Plan, is in accordance with the EPA Asbestos Hazard Emergency Response Act of 1987 (40 CFR Part 763). This memo is intended to fulfill annual notification and notification of activities including surveillance and inspection of asbestos materials, stating that the Asbestos Management Plan and any updates to the plan for this school district is available and **kept on file at each school, the Central Office and the Maintenance Office.**

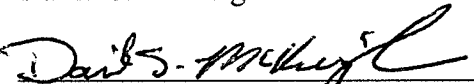
These records are available for review during the times: **8:00 a.m. to 4:00 p.m.**

For more information, please contact the following persons:

David S. McKeighan, LEA Designee      Phone: (518) 681-4571

Dr. Jon Hunter, Interim Superintendent      Phone: (518) 681-4125

Name: David S. McKeighan

Signature:   
Superintendent of Buildings & Grounds

## HUDSON FALLS CENTRAL SCHOOL DISTRICT – STUDENT QUESTIONNAIRE

STUDENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Reason for student's transfer: \_\_\_\_\_

Are you the legal parent? YES NO (Please Circle One)

If No, please state relationship to child: \_\_\_\_\_

ELEMENTARY LEVEL: K-5 Please check all that apply

- |  |   |
|--|---|
| <input type="checkbox"/> Enjoys School                   | <input type="checkbox"/> Almost always completes homework   |
| <input type="checkbox"/> Makes friends easily            | <input type="checkbox"/> Has difficulty completing homework |
| <input type="checkbox"/> Is happy and outgoing           | <input type="checkbox"/> Has trouble following school rules |
| <input type="checkbox"/> Follows school rules            | <input type="checkbox"/> Is nervous about a new school      |
| <input type="checkbox"/> Gets along well with classmates | <input type="checkbox"/> Has trouble making friends         |
| <input type="checkbox"/> Works independently             | <input type="checkbox"/> Is shy and withdrawn               |

What does your child like the most about school? \_\_\_\_\_

Is there anything you would like to share that will help us get to know your child? \_\_\_\_\_

EDUCATIONAL HISTORY: Please list all prior school districts your child has attended, by grade level.

UPK/Pre-K \_\_\_\_\_

K \_\_\_\_\_

2<sup>nd</sup> \_\_\_\_\_

4<sup>th</sup> \_\_\_\_\_

6<sup>th</sup> \_\_\_\_\_

8<sup>th</sup> \_\_\_\_\_

10<sup>th</sup> \_\_\_\_\_

1<sup>st</sup> \_\_\_\_\_

3<sup>rd</sup> \_\_\_\_\_

5<sup>th</sup> \_\_\_\_\_

7<sup>th</sup> \_\_\_\_\_

9<sup>th</sup> \_\_\_\_\_

11<sup>th</sup> \_\_\_\_\_

Has your child ever been suspended from school? YES NO (Please Circle)

If yes, what grade level and describe the reason(s) for suspension \_\_\_\_\_

Has your child ever received a psycho educational evaluation? YES NO If yes, at what grade level? \_\_\_\_\_

Has your child ever been diagnosed with ADD/ADHD? YES NO (Please circle one)

If yes, please note the year/age and physician \_\_\_\_\_

Has your child ever exhibited violent or threatening behaviors? YES NO (Please circle one)

If yes, please explain \_\_\_\_\_

Is your child/family currently working with any outside service providers such as social service workers, counselors/therapists, drug/alcohol counselors, probation, PINS Diversion, etc.? YES NO (please circle one)  
If yes, please list names and agencies of service providers below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do we have your permission to share information regarding your child with the above service providers?

YES NO (please circle one)

Do you need information about outside services for your family? YES NO (please circle one)

If yes, please note concerns \_\_\_\_\_

Please note here any specific behavioral/social/emotional concerns that you have about your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please note here any comments/suggestions you may have regarding your child's educational program: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
=====

### **BAND / ORCHESTRA / CHOIR**

If your child participates in a music program, please circle which program listed below.

**Band** 5 6 7 8 9 10 11 12      What instrument? \_\_\_\_\_ Own or Rent

**Orchestra** 4 5 6 7 8 9 10 11 12      What instrument? \_\_\_\_\_ Own or Rent

**Choir** 7 8 9 10 11 12

=====

Parent/Guardian Name (Please Print) \_\_\_\_\_

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

# 2020-21 School Year

## New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**  
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) <sup>2</sup>	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) <sup>3</sup>	Not applicable		1 dose	
Polio vaccine (IPV/OPV) <sup>4</sup>	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) <sup>5</sup>	1 dose	2 doses		
Hepatitis B vaccine <sup>6</sup>	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine <sup>7</sup>	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) <sup>8</sup>	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) <sup>9</sup>	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) <sup>10</sup>	1 to 4 doses	Not applicable		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.

d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grade 6: 10 years; minimum age for grades 7 through 12: 7 years)

a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2020-2021, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grade 6; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 7 through 12.

c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

d. Only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.

d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine

a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grade 7: 10 years; minimum age for grades 8 through 12: 6 weeks).

a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9, 10 and 11.

b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

d. If dose 1 was received at 15 months or older, only 1 dose is required.

e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

d. If one dose of vaccine was received at 24 months or older, no further doses are required.

e. PCV is not required for children 5 years or older.

f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: [www.health.ny.gov/prevention/immunization/schools](http://www.health.ny.gov/prevention/immunization/schools)

For further information, contact:

**New York State Department of Health  
Bureau of Immunization  
Room 649, Corning Tower ESP  
Albany, NY 12237  
(518) 473-4437**

**New York City Department of Health and Mental Hygiene  
Program Support Unit, Bureau of Immunization,  
42-09 28th Street, 5th floor  
Long Island City, NY 11101  
(347) 396-2433**

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New York State Department of Health/Bureau of Immunization  
[health.ny.gov/immunization](http://health.ny.gov/immunization)

5/20

**Hudson Falls and NYSED Health History—Two Page Form**  
Both pages must be completed.

Student Name:	DOB:
School Name:	Age:
Date of last health exam:	Date form completed:
List Medications:	
Physician's Name	

**Health History To Be Completed By Parent/Guardian, Provide Details To Any Yes Answers On Back.**  
Any medications to be taken at practice and/or athletic event will require the proper paperwork, contact school with questions.

Has/Does your child:		
<b>General Health Concerns</b>	Yes	No
1. Ever been restricted by a doctor, physician assistant, or nurse practitioner from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have an ongoing medical condition? <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell trait or disease <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
5. Been diagnosed with Mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any problems with his/her hearing or wears hearing aid(s)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have any problems with his/her vision or has vision in only one eye?	<input type="checkbox"/>	<input type="checkbox"/>
10. Wear glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergies</b>	Yes	No
11. Have a life threatening allergy? Check any that apply: <input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
12. Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breathing (Respiratory) Health</b>	Yes	No
13. Ever complained of getting more tired or short of breath than his/her friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
14. Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been told by their health care provider they have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
16. Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:		
<b>Concussion/ Head Injury History</b>	Yes	No
17. Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told he/she had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
19. Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
20. Ever had any unexplained seizures?	<input type="checkbox"/>	<input type="checkbox"/>
21. Currently receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Devices/Accommodations</b>	Yes	No
22. Use a brace, orthotic, or other device?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)? If yes there may be need for another required form to be filled out.	<input type="checkbox"/>	<input type="checkbox"/>
24. Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family History</b>	Yes	No
25. Have any relative who's been diagnosed with a heart condition, such as a murmur, developed hypertrophic cardiomyopathy, Marfan Syndrome, Brugada Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, or catecholaminergic polymorphic ventricular tachycardia?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Females Only</b>	Yes	No
26. Begun having her period?	<input type="checkbox"/>	<input type="checkbox"/>
27. Age periods began:	<input type="checkbox"/>	<input type="checkbox"/>
28. Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
29. Date of last menstrual period:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Males Only</b>	Yes	No
30. Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
31. Have groin pain or a bulge or hernia in the groin?	<input type="checkbox"/>	<input type="checkbox"/>

# Sample Recommended NYSED Interval Health History for Athletics – Page 2

Student Name: \_\_\_\_\_

School Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Has/Does your child:		
Heart Health	Yes	No
32. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
33. Ever complained of light headedness or dizziness during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
34. Ever complained of chest pain, tightness or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
35. Ever complained of fluttering in their chest, skipped beats, or their heart racing, or does he/she have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
36. Ever had a test by their medical provider for his/her heart (e.g. EKG, echocardiogram stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
37. Ever been told they have a heart condition or problem by a physician? If so, check all that apply: <input type="checkbox"/> Heart infection <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Other: _____		
Injury History	Yes	No
38. Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

Has/Does your child:		
Injury History <i>continued</i>	Yes	No
39. Ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
40. Ever had an injury, pain, or swelling of joint that caused him/her to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
41. Have a bone, muscle, or joint injury that bothers him/her?	<input type="checkbox"/>	<input type="checkbox"/>
42. Have joints become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Skin Health	Yes	No
43. Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
44. Have had a herpes or MRSA skin infections?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Health	Yes	No
45. Ever become ill while exercising in hot weather?	<input type="checkbox"/>	<input type="checkbox"/>
46. Have a special diet or have to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
47. Have to worry about his/her weight?	<input type="checkbox"/>	<input type="checkbox"/>
48. Have stomach problems?	<input type="checkbox"/>	<input type="checkbox"/>
49. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain fully any question you answered yes to in the space below. (Please print clearly and provide dates if known.)

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



HUDSON FALLS CENTRAL SCHOOL

DENTAL HEALTH CERTIFICATE

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Date of Comprehensive Dental Examination \_\_\_\_\_

Describe Dental Health Condition at time of Dental Exam:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The student is in fit condition of dental health to permit  
his/her attendance in school: (please check)

Yes

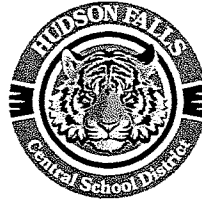
No

Dental Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Name/Address: \_\_\_\_\_

If you have questions or concerns regarding this request, please contact the  
nurse at (518) 681-4501

Kindergarten Center Health Office Fax # 518-681-4530



## **HFCSD Chromebook User Guidelines and Acceptable Use Policy Student Account Grades 6-12 Hudson Falls Central School District, Hudson Falls, NY 12839**

HFCSD is pleased to offer our students individual access to Chromebooks in grades 6-12. Access to Chromebooks are a privilege, not a right, and are to be used by HFCSD students only. They are provided to enhance, enrich and facilitate teaching and learning. Chromebooks are to be used for school related use, curriculum support, research, communications and other instructional purposes. We believe the advantages to having access to digital resources far outweigh any disadvantages to not providing access to technology in the school environment. To that end, students and staff have participated in appropriate trainings and use Positive Behavior Intervention Strategies to help facilitate the use of technology in the classroom.

The following guidelines are provided to help manage the use of this equipment. These guidelines apply to Chromebooks owned by HFCSD.

1. Chromebooks used by school district students remain the legal property of HFCSD.
2. Before a Chromebook is issued, the student and parent must sign the HFCSD Chromebook User Agreement, as well as the HFCSD Acceptable Use Policy. Both the User Agreement and the Acceptable Use Policy will remain on file with IT Administration.
3. Students will be responsible for any data on the Chromebook outside of the default image. Any intentional malicious activity caused by student data will be the student's sole responsibility.
4. In the event of problems with the Chromebook, the user will immediately bring it to the attention of the teacher and/or IT Department.
5. Chromebooks will be turned in at the end of the year for all students 6-11 or prior to a student transferring out of the district. Chromebooks can be turned in directly to the IT Dept located in the High School.
6. It is the student's responsibility to keep their assigned Chromebook secure and protected at all times.

### **Safe Care and Use**

1. Chromebooks should be shut down when not in use to conserve battery life and at the end of each day.
2. Never leave Chromebooks in an unsecure location or unattended in a classroom.
3. It is your responsibility to return your Chromebook at the end of each day to its designated charging station or arrive at school prepared with a fully charged Chromebook.
4. Carry your Chromebook closed. Do not place anything on the keyboard before closing the lid. (pens, earbuds, notebooks)
5. Keep drinks, food, lotions, liquids of any kind and other harmful materials away from your Chromebook.

## HFCSD Chromebook User Agreement And Acceptable Use Policy

- I will take good care of my Chromebook knowing that I will be issued the same Chromebook each year
- I will never leave my Chromebook unattended or in an unsecured or unsupervised location
- I will not loan my Chromebook to others
- I will be responsible for charging my Chromebook
- I will use my Chromebook for educational purposes only
- I will be responsible for all damage caused by neglect or abuse
- I understand any form of cyberbullying or online harassment is strictly prohibited and will result in removal of all email and Internet privileges
- I understand that failure to return my Chromebook if I move or at the end of the school year will be considered unlawful appropriation of public school property
- I understand that the use of the Internet as part of my educational program is a privilege, not a right, and inappropriate use will result in removal of these privileges

This application indicates that you agree and will follow the guidelines and regulations for Internet access and use of your Chromebook.

Student Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

I acknowledge this Chromebook belongs to HFCSD and is intended only for my individual school/district related use. I have read the Chromebook User Guidelines and agree to abide by the terms and conditions of those guidelines.

The terms and conditions of this agreement are subject to change.

I understand that violation of these guidelines may result in disciplinary action by the issuing administrative authority.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Print Parent/Guardian Name: \_\_\_\_\_

Questions regarding this application may be directed to [help@hfcSD.org](mailto:help@hfcSD.org) or by calling 681-4357

**Please sign and return to your homeroom teacher or the main office**

## TRANSFER NOTIFICATION

**This form must be completed for all transfer students and submitted to the Section 2 office.**

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

**Appeal Note:** Make sure all available information/documentation is submitted prior to the Transfer Committee's review. **NO appeal** will be entertained involving additional information that **WAS AVAILABLE** but not included prior to the Transfer Committee's review.

**PLEASE CHECK ONLY ONE (1) of THE FOLLOWING.**

**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 previous school indicating the specific circumstances which necessitated the transfer.
- \_\_\_\_\_ **School District of Residence (SDR):** (No change of residence, school registration change only.) Student is transferring to a school within the district boundaries of his/her residence.

**Exemption:**

- \_\_\_\_\_ **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 (6) months. The legal separation agreement or divorce document must address custody, child support, spousal support and distribution of assets and be filed with the County Clerk or issued by a Judge. **(proof required)**

\_\_\_\_\_ **Parent(s) Signature Attesting to Above**

\_\_\_\_\_ **Athletic Director's Verification**

- \_\_\_\_\_ **Homeless:** Student declared homeless by the Superintendent under McKinney-Vento Legislation (NYSED 100.2) **(STAC on file at the school)**

- \_\_\_\_\_ **Other Approved Exemption As Listed in the NYSPHSAA Handbook. Please Identify:** \_\_\_\_\_

- \_\_\_\_\_ **No Corresponding Change of Address:** This transfer has no corresponding change of address nor does a waiver or exemption apply.  
We understand that the student is ineligible per the NYSPHSAA Transfer Rule and subject to the limitations contained in NYSPHSAA Handbook #31(b) passed July 2019.

- \_\_\_\_\_ **Residency Change:** The entire family has abandoned the previous address and physically residing at the current address.

I/We attest that our previous residence has been abandoned by the immediate/entire family and our current residence has been established through action and intent. I/We attest that the immediate/entire family will be physically residing at our current address as inhabitants and intend 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.) I/We attest that the student has transferred without inducement, recruitment or having sought an athletic advantage.

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

Date: \_\_\_\_\_

By signing this document, I/We attest to the truth and accuracy of any and all information provided on this form.

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

Date: \_\_\_\_\_

Receiving School: \_\_\_\_\_ Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Registration/Transfer: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Date Entered 9<sup>th</sup> Grade \_\_\_\_\_ Did Student Repeat Any Grades: YES NO

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

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

**Parent(s) Names and Current Addresses**

Parent #1: Name \_\_\_\_\_ Address: \_\_\_\_\_

Parent #2: Name \_\_\_\_\_ Address: \_\_\_\_\_

Name of Previous School: \_\_\_\_\_ Did student participate in high school athletics at previous school? YES NO

**TO BE COMPLETED BY RECEIVING SCHOOL'S ATHLETIC DIRECTOR IN CONVERSATION WITH PREVIOUS SCHOOL.**

Address of Student While Attending Previous School: \_\_\_\_\_

With Whom Student Lived While Attending Previous School: \_\_\_\_\_

Dates of Attendance and Withdrawal of all Previous Schools: (grades 7-12)

1. School: \_\_\_\_\_ Attendance Dates: \_\_\_\_\_ Date of Withdrawal \_\_\_\_\_
2. School: \_\_\_\_\_ Attendance Dates: \_\_\_\_\_ Date of Withdrawal \_\_\_\_\_
3. School: \_\_\_\_\_ Attendance Dates: \_\_\_\_\_ Date of Withdrawal \_\_\_\_\_

**List All High School Sports Student Has Played (7-12 grade)  
Most Recent First**

Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____
Sport(s): _____	Year: _____	Level: _____	School: _____

Sports history verified by Receiving School's Athletic Director by:

\_\_\_\_\_ Telephone Conversation with \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ E-mail/Fax with \_\_\_\_\_ Date: \_\_\_\_\_

Failure to confirm after three (3) documented attempts:

1. Date/Time: \_\_\_\_\_ Method: \_\_\_\_\_
2. Date/Time: \_\_\_\_\_ Method: \_\_\_\_\_
3. Date/Time: \_\_\_\_\_ Method: \_\_\_\_\_

The Receiving School's Athletic Director has reviewed and verified all information on this document as accurate and true to the best of his/her knowledge.

Athletic Director Reviewed & Verified: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.

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: \_\_\_\_\_

**\* If any information provided in this document by the parent(s) and/or Athletic Director is deemed to be inaccurate or false, will result in eligibility Violations.**

## TRANSFER NOTIFICATION FORM GUIDELINES

- A Transfer Notification Form **MUST** be completed and submitted to the Section 2 office for any student having a change in registration and wishes to participate in sports.
- Upon receipt in the Section office, the student is eligible to practice, but cannot participate in a contest until approved by the Section.
- Incomplete forms will be returned.
- Make sure all available information/documentation is submitted prior to the Transfer Committee's review. NO appeal will be entertained involving additional information that WAS AVAILABLE but not included at the time of the original submission.
  - Example: For a Health & Safety Waiver alleging bullying and was reported to the police, the police report should be included with the submission. If it was available and just not submitted and there is no other information/documentation to support the waiver, the transfer will be denied and NO APPEAL will be entertained.
- **Waiver Requests:**
  - **Financial (#1):** This is for a student that due to a significant increase in expenses or a significant loss of income the family can no longer, due to the financial hardship, afford to send the student to a particular school.
    - The family must supply to the Athletic Director written description outlining the circumstances that led to the financial hardship.
    - Appropriate documentation must be supplied to the Athletic Director to support the financial hardship. This may include the following:
      - Evidence of loss of income or change in financial obligation that are not self-imposed.
      - Family W2 forms – pay stubs
      - Notarized statement from parent(s)
      - Statement from employer or professional with knowledge of circumstances
      - Most recent tax returns – two (2) years
      - Tuition invoice(s)
    - The above required documents can either be submitted to the Section 2 office with the Transfer Notification or directly by the previous school to the Section 2 office. However, no action will be taken by the Transfer Committee without these required documents.
      - This is different from a Divorced/Legally Separated Parents case where the receiving school's Athletic Director just needs to see the required legal document to confirm that it has been filed with the County Clerk or issued by a Judge
  - **Health & Safety (#2):** These could be for safety, mental health, personal relationships and other similar circumstances.
    - The previous school must supply to the Athletic Director written documentation from the Superintendent or High School Principal of the previous school indicating the specific circumstances which necessitated the transfer.
    - Any supporting documentation from a third party outside of the school may be submitted. (example: police report, DASA reports, diagnosis from health care professional treating student, etc.)

- The above required documents can either be submitted to the Section 2 office with the Transfer Notification or directly by the previous school to the Section 2 office. However, no action will be taken by the Transfer Committee without these required documents.
  - This is different from a Divorced/Legally Separated Parents case where the receiving school's Athletic Director just needs to see the required legal document to confirm that it has been filed with the County Clerk or issued by a Judge.
- **School District of Residence (#3):** In this case there is no change in residence of the student. It involves only a change in registration. (example: A student lives in Guilderland but attends CBA. The student now is transferring to Guilderland HS. That would be approved. If the student transferred to Watervliet, but is residing in Guilderland, that would be denied.)
  - It is important that the previous address and the present address are the same. (#15 & #16)

➤ **Exemptions:**

- **Divorced/Legally Separated Parents (#4):** A student from divorced or "legally" separated parents who moves into a new school district with one of the aforementioned parents. Such a transfer is allowed once every six (6) months. The legal separation agreement or divorce document **MUST** address custody, child support, spouses support and distribution of assets **AND** be filed with the County Clerk or issued by a Judge.
  - The following are examples:
    - A student who lives with one parent in the previous school district and now goes to live with the other parent in the receiving school district. (This is NOT a simple Residency Change. It is a Divorced/Legally Separated Parents case.)
    - A student who lives with both parents in the previous school district and now moves with only one of the parents into the receiving school district.
    - A student who lives with one parent in the previous school district and now moves with that same parent into the receiving school district. This is a Residency Change, NOT a Divorced/Legally Separated Parents case.
  - **Proof is Required –**
    - The parent(s) must provide to the Athletic Director a copy of the legal document that has been filed with the County Clerk or issued by a Judge.
    - Both the Athletic Director and the parent(s) must sign the Notification Form in this Section. By signing it the parent(s) are attesting to the fact that the proper documentation has been provided and the Athletic Director attests to the fact that he/she has received/verified the required documentation.
- **Homeless (#5):** This is for a student that has been declared homeless by the Superintendent under McKinney-Vento Legislation (NYSED 100.2).
  - The STAC form must be completed and on file at the receiving school.

➤ **No Corresponding Change of Address (#6):** This is for students that do not have a corresponding change of address (immediate/entire family), nor does the transfer fall under a waiver or exemption list above.

- By checking this category the Athletic Director and parents understand that the student is ineligible per the NYSPHSAA Transfer Rule and is subject to the limitation contained in the NYSPHSAA Handbook #31(b) passed in July 2019.

- ***A student who transfers without a corresponding change of residence of his/her parents (or other person(s) with whom the student has resided for at least six months prior) is ineligible to participate at the varsity level in any interscholastic athletic contest in a particular sport for a period of one (1) year if as a 9-12 student participated in that sport during the one (1) year period immediately preceding his/her transfer. NOTE: Students in grades 7-10, shall be eligible to participate at the sub-varsity level and practice at all levels, while students in grades 11-12 shall be limited to practice (all levels) only. (July 2019)***
- **Residency Change (#7):** The immediate/entire family has abandoned the previous address and has physically moved and is residing at the current address. The mere renting of property within the District does not confer residency.
- **#8 – Parent Signature** – The parent(s) are attesting to the information and documentation they have provided to the school district as being true and accurate. In the case of a Residency Change, they are also attesting that they have abandoned the previous address and entire family has moved to the present address.
- **#9 to #19:** These questions are very important and for the most part are self-explanatory. The Athletic Director should complete each of these questions with the assistance of the parents and Receiving School's admissions office.
- **#20 & #21b:** The Athletic Director of the Receiving School should contact the Previous School and answer each of these questions. If unable to obtain the answers after attempting to contact the Previous School on three (3) different occasions, complete #21b.
- **#22:** The Receiving School Athletic Director must sign and date here. This signature confirms that he/she has reviewed and verified all the information on this document and that it is accurate and true to the best of his/her knowledge.
- **#23:** The Athletic Director should explain to the Superintendent and High School Principal that by signing this document they are responsible for verification of statement and other eligibility requirements. It is more than a simple signature that a student has transferred to this District.



Dear Parents:

Under the Every Student Succeeds Act, The NYS Education Department requires school districts to gather data regarding the military involvement of the parents or guardians of students enrolled in their district. Military involvement includes Army, Navy, Air Force, Marine Corps, or Coast Guard.

The information required pertains to any student whose mother, father, or legal guardian meets the following criteria:

- A) Parent or guardian is full-time active duty in military
- B) Parent or guardian is a civilian working on a military post

Completion of the survey need only be done by those individuals who meet the criteria noted above.

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

\_\_\_\_Active Duty    \_\_\_\_Civilian  
(please check one)

Date entered active duty \_\_\_\_\_ Military Branch \_\_\_\_\_

Custodial Students:

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

Name \_\_\_\_\_ Grade \_\_\_\_\_

Thank you for your cooperation~

*Dr. Jon Hunter*  
*Interim Superintendent of Schools*