

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

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of School/LEA: _____

Legal Name of Student : _____
Last First Middle

Gender: Male / Female Date of Birth: ____ / ____ / ____ Grade: ____ Student ID # ____
Month Day Year PreK - 12

Current Address: _____ Phone: ____ - ____ - ____
House # Street Apt/Lot # City

Previous Address: _____
House # Street Apt/Lot # City

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 that are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one box)

_____ In permanent housing (*your own apartment or house*)

_____ In a shelter

_____ With another family because of loss of housing or economic hardship (referred to as "doubled up")

_____ In a hotel/motel

_____ In a car, park, bus, train or campsite

_____ Other temporary living situation (please describe): _____

Print name of Parent, Guardian or
Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date: _____

Office Use Only: Signature _____ Date: _____ Time: _____

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

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 1153 Burgoyne Avenue Fort Edward, NY 12828 Fax: (518) 681-4107 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

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 9th 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

PART 2: ENROLLMENT/REGISTRATION REQUIREMENTS

1st-12th Grades

PLEASE BE PREPARED TO SUBMIT THE FOLLOWING ADDITIONAL REQUIREMENTS AFTER STUDENT IS ENROLLED

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 5-10)**

___ **AUP – INTERNET USAGE FORM (grades 11-12)**

___ **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

rev 3/30/16

Dear Parent, Guardian, and School Staff:

New York State Education Law Section 409-H, effective July 1, 2001, requires all public and nonpublic elementary and secondary schools to provide written notification to all persons in parental relation, faculty, and staff regarding the potential use of pesticides periodically throughout the school year.

The Hudson Falls Central School District is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. We will use Integrated Pest Management (IPM) practices. IPM practices are designed to have minimal effects on non-target species and on human health. Certain methods of pest control may not be preceded by a notification.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

If you would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur in your school, please complete the form below and return it to David McKeighan, the Hudson Falls Central School District pesticide representative at 3665 Burgoyne Avenue, Hudson Falls, NY 12839. Tel 681-4570. Fax no. 747-8554. E-mail dmckeighan@hfcasd.org.

Hudson Falls Central School District Request for Pesticide Application Notification (please print)		
_____ School Building		
Please Print Parent/Guardian Name:		Address:
Date:	Phone:	Town:

Please feel free to contact David McKeighan the Hudson Falls Central School District pesticide representative at 3665 Burgoyne Avenue, Hudson Falls, NY 12839. Tel 681-4570. Fax no. 747-8554. E-mail dmckeighan@hfcasd.org for further information on these requirements.

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

___ Enjoys School

___ Almost always completes homework

___ Makes friends easily

___ Has difficulty completing homework

___ Is happy and outgoing

___ Has trouble following school rules

___ Follows school rules

___ Is nervous about a new school

___ Gets along well with classmates

___ Has trouble making friends

___ Works independently

___ 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 _____

1st _____

2nd _____

3rd _____

4th _____

5th _____

6th _____

7th _____

8th _____

9th _____

10th _____

11th _____

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 _____

2018-19 School Year New York State Immunization Requirements for School Entrance/Attendance¹

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). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. 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 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	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 booster (Tdap) ³		Not applicable			1 dose
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose		2 doses		
Hepatitis B vaccine ⁶	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 ⁷	1 dose	2 doses	1 dose	2 doses	1 dose
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable		Grades 7, 8 and 9: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses		Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses		Not applicable		

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:		
General Health Concerns	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"/>
Allergies	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"/>
Breathing (Respiratory) Health	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:		
Concussion/ Head Injury History	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"/>
Devices/Accommodations	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"/>
Family History	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"/>
Females Only	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"/>
Males Only	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: _____	<input type="checkbox"/>	<input type="checkbox"/>
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.)

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: _____

In accordance with New York State Education Law, a dental health certificate is requested of all new entrants and students in grades K, 2, 4, 7, and 10. The date of the dental health exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.

Parents/Guardians of students without dental insurance or with limited insurance, should contact the Health Office in which their child attends. Parents/guardians needing assistance in locating a dental provider should also contact their child's Health Office. If you have questions or concerns regarding this request, please contact Brenda Brooks, School Nurse-Teacher at (518) 747-2121 ext. 4218.



HFCSD Chromebook User Guidelines and Acceptable Use Policy Student Account

Hudson Falls Central School District, Hudson Falls, NY 12839

HFCSD is pleased to offer our students individual access to Chromebooks in grades 5-10. 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 or building lab assistant.
5. Chromebooks will be turned in at the end of the year for all students 5-8 or prior to a student transferring out of the district. Chromebooks can be turned in to the building lab assistant or directly to the IT Dept.
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 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 or by calling 681-4357

Please return this form to your homeroom teacher or the main office.

ATHLETIC PARTICIPATION
REGISTRATION FORM

Date: _____ Student ID#: _____

Entering Grade: _____ Gender: Male/Female DOB: _____

Student Name: _____ Phone: _____

Address: _____

Residence in School District

The person(s) you are living with in this district: _____

Parent Name: _____ Phone: _____

*****Previous School Information*****

Has your child previously played a sport? Yes _____ No _____

If yes, please fill out transfer notification form, if no, continue to military survey

Previous School: _____

Sports Played in Previous School

Level and Number of Years Played

Fall Sport _____

___ Modified ___ JV ___ Varsity

Winter Sport _____

___ Modified ___ JV ___ Varsity

Spring Sport _____

___ Modified ___ JV ___ Varsity

Previous Address: _____

The person(s) you are living with in this district: _____

Reason for leaving previous school: _____

*****Academic Information*****

Year Entered 9th grade: _____ Verification: _____

Counselor's initials

Have you ever been retained in a grade in High School? ___yes ___no

If Yes, which grade? _____

PLEASE LIST OTHER HIGH SCHOOLS THAT THE STUDENT HAS ATTENDED



TRANSFER NOTIFICATION

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

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

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

Please 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 at the time of the original submission.

Waiver Request Financial: Requires documented proof of a significant loss of income or a significant increase in expenses. OR Health & Safety: Written documentation from the Superintendent of Schools or HS Principal of the sending school indicating the specific circumstances which necessitated the transfer.

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

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

Parent(s) Signature

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

Other - Refer to By-Law #30 and NYSPHSAA applicable exemption.

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

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

Parent Signature: Date:

Print Parent's Name:

PART ONE TO BE COMPLETED BY STUDENT'S RECEIVING SCHOOL

Receiving School: Student's Name:

Date of Transfer: Date of Birth: Grade Level: Date Entered 9th Grade:

Student/Family Previous Address:

Student/Family Present Address:

Parent's Names and Current Address(es) (Parent #1's name & address)

(Parent #2's name & address)

Name of Sending School

Did student participate in athletics at sending school? Yes No

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

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

Superintendent's signature Date

Principal's signature Date

Athletic Director's signature Date

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

Name of Student _____ Date entered 9th grade _____

Did student repeat any grades? _____ If yes, which ones? _____

Name of School(s) Attended Prior to Transfer _____

Date of entrance to this school _____ Date of withdrawal from this school _____

Student's address while attending the above school _____

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

Relationship of this (these) person(s)? _____

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

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

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

Superintendent's signature _____ Date _____

Principal's signature _____ Date _____

Athletic Director's signature _____ Date _____

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 ~

*Linda Goewey,
Superintendent of Schools*