

Fabius-Pompey Elementary School Registration Packet Kindergarten - Grade 5



Packet Includes:

- Registration Form
- Housing Questionnaire
- Home Language Questionnaire
- Health History
- NYS Health Examination Form
- Records Request Form (if applicable)

Please Provide:

- Proof of Residency
- Proof of Age
- Parent/Guardian Photo ID
- Evidence of Immunizations and Physical Examination

Please complete and return to:
Stephanie O'Neil, Registrar
7800 Main Street
Fabius, NY 13063
315-683-5301

FABIUS-POMPEY CENTRAL SCHOOL DISTRICT

1211 Mill Street
Fabius, NY 13063

Request for Student Records

Parent/Guardian must complete this form and sign below.

- **Previous School's Information:** (*Records request will be sent here*)

School _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

- **Parent's Authorization of Release:**

Student's Name _____

Present Grade _____ Date of Birth _____

I consent to the release of my child's records, as indicated below:

Parent's Name Printed _____

Parent's Signature _____ Date _____

-
- **Registrar, please provide all records of the above student, including:**

- All previous **academic** records
- All **classes in progress** and grades
- All **health** records, including immunizations and attendance
- All **test results**, including standardized tests
- Any **psychological testing** and/or disability documentation
- Any other information which would assist this student in transition

Please send all records to Stephanie O'Neil at the Fabius-Pompey Elementary School

soneil@fabiuspompey.org

Fax: 315-683-5680

Fabius Pompey Elementary School

7800 Main Street

Fabius, NY 13063

**FABIUS-POMPEY CENTRAL SCHOOL DISTRICT
REGISTRATION FORM**

Student's Name: _____
Last First Middle

Date of Birth: _____ Place of Birth: _____ Gender: ___ Male ___ Female Enrollment Grade: ____
mm/dd/yyyy

Permanent Address: _____
Street / P.O. Box _____
City / State / Zip _____ Home Phone: _____

Description of Location: _____

School Previously Attended: _____ Phone: _____

Previous School Address: _____
Street _____ City / State / Zip _____

****Please complete the Request for Student Records form.***

Parent/Guardian Name: _____ **Relationship to Student:** _____

Occupation: _____ Place of Employment: _____

Email Address: _____ Cell Phone: _____ Work Phone: _____

Home / Mailing Address (if different than student): _____
Street / P.O. Box _____
City / State / Zip _____ Home Phone (if different than student): _____

Parent/Guardian Name: _____ **Relationship to Student:** _____

Occupation: _____ Place of Employment: _____

Email Address: _____ Cell Phone: _____ Work Phone: _____

Home / Mailing Address (if different than student): _____
Street / P.O. Box _____
City / State / Zip _____ Home Phone (if different than student): _____

Other Relationship Name: _____ **Relationship to Student:** _____

Occupation: _____ Place of Employment: _____

Email Address: _____ Cell Phone: _____ Work Phone: _____

Home / Mailing Address (if different than student): _____
Street / P.O. Box _____
City / State / Zip _____ Home Phone (if different than student): _____

Siblings, extended family members and others living at home address:

Name	Relationship to student	Date of birth if sibling/child	Current grade if school age

Student's Name: _____
Last First Middle

Is there a custody agreement in place for your child? ____ Yes ____ No
If yes, which parent or person in parental relation has physical custody? ____ Mother ____ Father ____ Other (specify relationship) ____
***If yes, please provide the District with a copy of the agreement.** Other relationship: _____
If no, and parents reside at separate addresses, please provide the District with a notarized statement acknowledging agreement by both parents as to which parent is designated as parent with residential custody.

Emergency contact names and relationship (if parents are unavailable): _____

Address: _____ Phone: _____

Adults authorized to pick up your child (name, relationship, and phone number):

Please indicate services previously/currently provided to your child, including number of years provided:

____ Speech/Language ____ Special Education ____ OT/PT ____ English as a New Language
____ Psychological/Counseling ____ Gifted ____ Math Support ____ Reading Support

Does your child currently have an IEP? ____ Yes ____ No Does your child have a 504 Plan? ____ Yes ____ No

The following questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services that you and your child may be eligible to receive.

1. Is your current address a temporary living arrangement? ____ Yes ____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship? ____ Yes ____ No

***If you answered yes to the above questions, please complete the Enrollment Form/Residency Questionnaire.**

Student Racial and Ethnic Identification. This information is collected in accordance with the policy adopted by the District to satisfy reporting requirements by State and Federal Education Departments, to plan educational programs available to all students and to analyze differences in academic performance, attendance and completion of school.

Is your child Hispanic, Latino or of Spanish origin? ____ Yes ____ No
(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.)

Please select one or more races from the following racial groups that apply to your child:

____ American Indian/Alaskan Native ____ Asian ____ Black or African-American ____ Native Hawaiian/Other Pacific Islander
____ White

Migrant Status

Does either parent/guardian qualify legally as a migrant worker in the agricultural industry? ____ Yes ____ No

***If you answered yes, please complete the NYS Migrant Education Program Identification & Recruitment Parent Survey**

Language

Is English the primary language spoken in the home? ☐ Yes ☐ No

****If you answered no, please complete the NYS Home Language Questionnaire.***

If no, what is the primary language spoken in the home? _____

Active Military Service

Is either parent/guardian actively serving in the military? ☐ Yes ☐ No

Any additional information which will help us to understand your child: _____

Name of Parent/Person in Parental Relation (Printed)

Signature of Parent/Person in Parental Relation

Date

The information you have provided on this form is confidential. It is protected by the Family Educational Rights and Privacy Act (1974), which prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please call the Registrar at (315) 683-5857 with any questions regarding required proof of residency, proof of age, health records or proof of guardianship/custody.

New York State Housing Questionnaire

Identifying and serving students in temporary housing under the McKinney-Vento Act and NYS Ed Law §3209

This form is to be completed when a student first enrolls, and any time a change in housing status occurs. There are no wrong answers. This form may be filled out independently, or the McKinney-Vento Liaison can assist. To access a list of McKinney-Vento Liaisons, please visit <https://www.nysteachs.org/liaisons>

District or LEA	School Name
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About this form and your rights

Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The **McKinney-Vento Homeless Assistance Act**, together with **New York State Education Law Section §3209**, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home.

Eligible students have the right to:

- ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing.
- ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location).
- ✓ Enroll and start school right away, even without a birth certificate, proof of residency, immunization records, or school records.
- ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (If within 50 miles).
- ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available.

This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Providing it will not affect your immigration status or your eligibility for enrollment or other services.

STUDENT INFORMATION:

Student Name (Last, First)	Student Grade Level (Preschool-12)
Student Gender ☐ M ☐ F ☐ X = Nonbinary	Student Date of Birth (Month/Day/Year)
Parent/Legal Guardian Name	
Phone Number	E-Mail Address
Address where the student is currently living	

Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate**. Check every box that describes where **the student** is residing right now.

- ☐ Permanent housing: you own or rent a fixed, regular, and adequate home
- ☐ Doubled up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason
- ☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: _____
- ☐ In a hotel or motel because there is no other alternative, adequate place to stay
- ☐ In a car, park, campsite, bus or train station, abandoned building, or another place not meant for stable habitation or established dwelling.
- ☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in
- ☐ Displaced by a fire, flood, natural disaster, or other emergency
- ☐ Another temporary situation not listed here: _____

Is there anything else you would like us to know about your situation? (optional)

Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

☐ Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.

Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Accuracy of Information and Signature

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

Name (print): _____

Signature: _____ Date: _____

An unaccompanied homeless youth may sign on their own behalf.

Need help? Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit nysteachs.org for more information.

OFFICIAL USE ONLY (School Staff)

Date received: _____ Received by: _____ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

Homeless Primary Nighttime Residence Code (SIRS):

☐ D = Doubled up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): _____ Date: _____ ☐ Family declined to provide information

Notes:



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:

First Middle Last

DATE OF BIRTH:

GENDER:

Month Day Year

☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name

First Name

Relation to

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other	_____
			specify
2. What was the first language your child learned?	☐ English	☐ Other	_____
			specify
3. What is the Home Language of each parent/guardian?	☐ Parent 1	☐ Parent 2	_____
	☐ Guardian(s)		_____
			specify
4. What language(s) does your child understand?	☐ English	☐ Other	_____
			specify
5. What language(s) does your child speak?	☐ English	☐ Other	☐ Does not speak
			specify
6. What language(s) does your child read?	☐ English	☐ Other	☐ Does not read
			specify
7. What language(s) does your child write?	☐ English	☐ Other	☐ Does not write
			specify

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

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT
INFORMATION SYSTEM:

District Name (Number) & School:

Address:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure
☐ ☐ ☐ *If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?
☐ No ☐ Yes – Type of services received: _____

Age at which services received (Please check all that apply):
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? _____

 Signature of Parent or of Person in Parental Relation

 Date

Relationship to student: ☐ Parent ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

MO. DAY YR.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

- ☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL
ADMINISTRATION:

MO. DAY YR.

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

- ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

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

FABIUS-POMPEY ELEMENTARY SCHOOL
Health History Screening Form
(Kindergarten - Grade 5)

Student's Name _____ Date of Birth ____/____/____

Student's Health Care Provider/Address _____

1. Has your child ever had any of the following?

____ heart disease ____ serious injuries ____ asthma ____ diabetes
____ head injuries ____ ADHD ____ anxiety ____ food allergies
____ epilepsy/seizures ____ ear infections ____ kidney disease ____ other
____ environmental allergies

2. Any surgeries? _____ Please list: _____

3. Ever been hospitalized? _____ For what reason? _____

4. Please list all medications your child presently takes and the conditions that they are prescribed:

5. Will your child need to take medication at school? _____

Medication: _____

For: _____

6. Has your child had difficulty seeing? _____ Glasses? _____ Last eye exam? _____

7. Has your child had difficulty hearing? _____ Tested? _____ Results? _____

8. Has your child ever seen a dentist? _____ Last exam? _____

9. Does your child have any food allergies? _____ To what? _____ Medications
prescribed? _____ What? _____ Will they take them at school? _____

10. Does your child have a bee sting allergy? _____

Medication: _____

Will you provide for school-use with a doctor's note?: _____

11. Any other comments or concerns? _____

Any medications at school must be done so following the medication administration policy.
I understand that all information, reports and/or testing results will be treated confidentially.

Parent/Guardian Signature Date

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR IF AN AREA IS NOT ASSESSED, INDICATE NOT DONE									
Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).									
STUDENT INFORMATION									
Name:				Affirmed Name (if applicable):				DOB:	
Sex Assigned at Birth: ☐ Female ☐ Male				Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X					
School:						Grade:		Exam Date:	
HEALTH HISTORY									
If yes to any diagnoses below, check all that apply and provide additional information.									
☐ Allergies		Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached							
☐ Asthma		Type: ☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached							
☐ Seizures		Type: ☐ Medication/Treatment Order Attached ☐ Date of Last Seizure: ☐ Seizure Care Plan Attached							
☐ Diabetes		Type: ☐ 1 Type: ☐ 2 ☐ Medication/Treatment Ordered Attached ☐ Diabetes Medical Management Plan Attached							
Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.									
BMI _____ kg/m2 Percentile (Weight Status Category) ☐ <5 th ☐ 5 th - 49 th ☐ 50 th - 84 th ☐ 85 th - 94 th ☐ 95 th - 98 th ☐ 99 th and >									
Hyperlipidemia: ☐ Yes ☐ No ☐ Not Done						Hypertension: ☐ Yes ☐ Not Done			
PHYSICAL EXAMINATION/ASSESSMENT									
Height:		Weight:		BP:		Pulse:		Respirations:	
Laboratory Testing		Positive		Negative		Date		Lead Level Required for PreK & K	
TB-PRN		☐		☐				☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL	
Sickle Cell Screen-PRN		☐		☐					
☐ System Review Within Normal Limits ☐ Abnormal Findings—List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)									
☐ HEENT		☐ Lymph nodes		☐ Abdomen		☐ Extremities		☐ Speech	
☐ Dental		☐ Cardiovascular		☐ Back/Spine/Neck		☐ Skin		☐ Social Emotional	
☐ Mental Health		☐ Lungs		☐ Genitourinary		☐ Neurological		☐ Musculoskeletal	
☐ Assessment/Abnormalities Noted/Recommendations:						Diagnoses/Problems (list): ICD-10 Code*			
☐ Additional Information Attached						*Required only for students with an IEP receiving Medicaid			

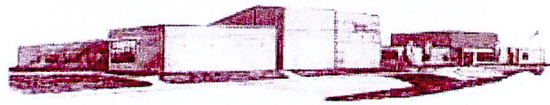
Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for New Entrants, PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening ☐ Pass ☐ Fail					☐
Notes:					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes		☐
Notes:					
Scoliosis Screening Required for Boys grade 9 and Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐	☐
Notes:					
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ Family cardiac history reviewed – required for sports (Dominic Murray Sudden Cardiac Arrest Prevention Act)					
☐ Student may participate in all activities without restrictions.					
If Restrictions Apply , complete the information below.					
☐ Student is restricted from participation in:					
☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, or Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, or Volleyball					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.					
☐ Other Restrictions:					
☐ Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

FABIUS-POMPEY CENTRAL SCHOOL DISTRICT

1211 Mill Street
FABIUS, NEW YORK 13063

BOARD OF EDUCATION

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MIDDLE SCHOOL- HIGH SCHOOL
(315) 683-5811



ELEMENTARY SCHOOL
(315) 683-5857

SUPERINTENDENT
OF SCHOOLS
Lloyd L. Peck, Ed.D.

DISTRICT OFFICE
(315) 683-5301
FAX (315) 683-5827

ASSISTANT SUPERINTENDENT
OF BUSINESS SERVICES
Daniel S. Silky

Fabius-Pompey CSD Photo/Media Release Opt-Out Form

*Note: Complete this form **ONLY** if you **DO NOT** give permission for your child to appear in media or school publicity images/video as outlined below. This form only applies to the current school year and is required to be completed annually by parents/guardians. Each student must have their own form. Select those that apply. Please email form to PIO@fabiuspompey.org or drop off at the student's respective building main office.*

Student Name: _____

My child's photograph, artwork, or film-footage may NOT be released by Fabius-Pompey CSD to the public through means of the **Fabius-Pompey website and social media account(s) including Facebook and Instagram.**

A copy of the completed form will be placed in the student's file for reference.

Parent/Guardian Name: _____
(Please Print)

Parent/Guardian Signature: _____
Date: _____