

# UNATEGO CENTRAL SCHOOL

2641 State Highway 7  
P.O.Box 483  
Otego, New York 13825-9795  
www.unatego.org

David S. Richards, Ph.D  
Superintendent of Schools  
(607) 988-5038

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## District Registrar Request for Records

I hereby authorize \_\_\_\_\_  
(Previous school)

\_\_\_\_\_  
(Address of previous school)

### Please forward the following information:

Academic Records  
Health Records  
Birth Certificate  
Discipline Records  
Social History, Psychological, etc. Committee on Special Education Records

STUDENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

PARENTS NAME \_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

Please forward his/her most recent documents as soon as possible to the following:

**Sherry Maruszewski, District Registrar**  
**Email: [smaruszewski@unatego.stier.org](mailto:smaruszewski@unatego.stier.org)**  
**Phone: (607) 988-5097**  
**Fax: (607) 988-1050**

**Unatego Central School - Student Information Sheet**

Student name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
911 Address: \_\_\_\_\_ County: \_\_\_\_\_  
\_\_\_\_\_ Grade: \_\_\_\_\_

Mailing address: \_\_\_\_\_  
\_\_\_\_\_

Home phone: \_\_\_\_\_  
Student e-mail: \_\_\_\_\_ Student cell phone: \_\_\_\_\_

Ethnicity: **Check one:**       Yes, Hispanic       No, not Hispanic

**Check all groups that apply to your child**

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

Student gender:       Male       Female

Will the student ride the bus? \_\_\_\_\_  AM       PM  
Dropped off by: \_\_\_\_\_ Picked up by: \_\_\_\_\_

Custody:       Parents       Mother       Father       Joint       Other  
Lives with:       Parents       Mother       Father       Other- Specify \_\_\_\_\_

**Guardian Information:**

Guardian 1: _____	Guardian 2: _____
Relationship: _____	Relationship: _____
Home phone: _____	Home phone: _____
Address: _____	Address: _____
City/State: _____	City/State: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Work phone: _____	Work phone: _____
Cell phone: _____	Cell phone: _____
E-mail: _____	E-mail: _____

Guardian 3: _____	Guardian 4: _____
Relationship: _____	Relationship: _____
Home phone: _____	Home phone: _____
Address: _____	Address: _____
City/State: _____	City/State: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Work phone: _____	Work phone: _____
Cell phone: _____	Cell phone: _____
E-mail: _____	E-mail: _____

**Who lives in the home with the student:** (Include all children & adults)

<u>Name</u>	<u>Relationship</u>	<u>Birthdate</u>	<u>Grade/Occupation</u>	<u>Place Employed</u>	<u>Grade Completed</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Please list siblings:**

<u>Name</u>	<u>Birthdate</u>	<u>Grade</u>	<u>Name</u>	<u>Birthdate</u>	<u>Grade</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Previous school information:**

Has this student ever attended another school district?  Yes  No

If "yes" please list schools and grade attended: \_\_\_\_\_

Has this child ever been referred to the Committee of Special Education (CSE)?  Yes  No

Does this student currently receive special education services?  Yes  No

Does this student have an:  IEP  504

**Parental Rights Notification:**

It is your right to have your child referred and evaluated for the purposes of special education services or programs. Should you have any questions regarding this process, please access *A Parent's Guide to Special Education* on the New York State Education website or contact Special Programs, at (607) 988-5034

Our school district uses a mass notification system to notify you of certain events, including attendance, school delays, closing or other emergencies. By signing this form you are approving the use of the numbers that you've provided to be contacted in this manner. If you do not approve of this please notify the district in writing.

Parent/ Guardians signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Unatego Central School District Emergency Contact Sheet

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

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

**Emergency Contact #1:** \_\_\_\_\_

This person has permission to sign out this student:  Yes  No Relationship: \_\_\_\_\_ (to student)

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
(circle one) Cell Home Work (circle one) Cell Home Work

**Emergency Contact #2:** \_\_\_\_\_

This person has permission to sign out this student:  Yes  No Relationship: \_\_\_\_\_ (to student)

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
(circle one) Cell Home Work (circle one) Cell Home Work

**Emergency Contact #3:** \_\_\_\_\_

This person has permission to sign out this student:  Yes  No Relationship: \_\_\_\_\_ (to student)

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
(circle one) Cell Home Work (circle one) Cell Home Work

**Emergency Contact #4:** \_\_\_\_\_

This person has permission to sign out this student:  Yes  No Relationship: \_\_\_\_\_ (to student)

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
(circle one) Cell Home Work (circle one) Cell Home Work

**Emergency Contact #5:** \_\_\_\_\_

This person has permission to sign out this student:  Yes  No Relationship: \_\_\_\_\_ (to student)

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_  
(circle one) Cell Home Work (circle one) Cell Home Work

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Special medical considerations: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: (dose and time) \_\_\_\_\_

Parent/ Guardian (print): \_\_\_\_\_ Phone: \_\_\_\_\_

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

**\*Please note only people listed above under the sign out/ pick up list will be able to pick up your child.**

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

### ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: \_\_\_\_\_

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

Name of Student: \_\_\_\_\_  
Last First Middle

Gender:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_ ID#: \_\_\_\_  
Month Day Year (preschool-12) (optional)

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

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth 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 a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): \_\_\_\_\_
  
- In permanent housing

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

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

**Date**  
If the student is **NOT** living in permanent housing, proof of residency and other documents normally needed for enrollment are **not** required and the student is to be immediately enrolled. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

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



# 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 Please print or type clearly

---

SCHOOL GRADE

---

STUDENT NAME

---

DATE OF BIRTH Month: Day: Year:

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STUDENT IDENTIFICATION NUMBER

---

COUNTRY OF BIRTH / ANCESTRY

---

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

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NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

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DETERMINATION:  Possible LEP  
 English Proficient

(✓ boxes that apply)

1. What language(s) is spoken in the student's home or residence?  English  Other \_\_\_\_\_ specify

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2. What language(s) are spoken most of the time to the student, in the home or residence?  English  Other \_\_\_\_\_ specify

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3. What language(s) does the student understand?  English  Other \_\_\_\_\_ specify

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4. What language(s) does the student speak?  English  Other \_\_\_\_\_ specify

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5. What language(s) does the student read?  English  Other \_\_\_\_\_  Does Not Read specify

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6. What language(s) does the student write?  English  Other \_\_\_\_\_  Does Not Write specify

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

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Month: Day: Year:

Signature of Parent/Guardian/Other

Date

School District  
HEALTH RECORD – Please Print

Name \_\_\_\_\_ Grade \_\_\_\_\_  Male  Female

Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

**Health History (Please add age child had diagnoses):**

Chicken Pox \_\_\_\_\_

Diabetes \_\_\_\_\_

Measles \_\_\_\_\_

Epilepsy \_\_\_\_\_

Mumps \_\_\_\_\_

Heart Disease \_\_\_\_\_

Pneumonia \_\_\_\_\_

Asthma \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Allergies \_\_\_\_\_

Scarlet Fever \_\_\_\_\_

Ear Conditions \_\_\_\_\_

Serious Injury \_\_\_\_\_

Hearing Problems \_\_\_\_\_

Operations \_\_\_\_\_

Vision Problems \_\_\_\_\_

My child has the following allergies that may require special handling in an emergency:

Allergy	Reaction	Treatment

List any Medical Conditions (type, treatment, and doctor) and any medication (type, reason):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

⇒ Health Appraisal: Please submit a copy of child's latest Health Appraisal (physical). This must be received no later than 30 days following student's entrance to school. If not received, the student will be scheduled for a health appraisal by the school physician.

⇒ Immunizations: Please submit a copy of child's immunization record signed by your health care provider. This must be received no later than 14 days following student's entrance to school.

All students in New York State are required to be properly immunized against the following:

- Diphtheria/Tetanus/Pertussin
- Measles/Mumps/Rubella
- Varicella (or MD documentation)
- Pneumococcal disease (PCV)
- Polio
- Haemophilus influenza type b (Hib)
- Hepatitis B

If your child is lacking adequate shots, please call the County Health Department/Clinic at 753-5203 or speak with your health provider to schedule an appointment. The American Academy of Pediatrics recommendations exceeds the New York Guidelines for Public Education, and you are highly encouraged to follow the AAP's guidelines. You may check with your doctor, or the school nurse for this information.

**Person(s) to Contact in Case of Emergency:**

If my child needs to be sent home from school and I am not there or able to be reached, the school may contact one of the people whose names have been provided below who are authorized to pick up my child.

(Please indicate Relationship to Student, i.e. grandparent, aunt, uncle, sibling, etc. and note whether number is home, cell, or work.)

	Name	Relationship	Daytime Phone #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

In the event of a medical emergency, if none of the above named can be reached, the personal/school physician will be contacted. If necessary, the student will be taken to the nearest emergency first aid station by ambulance.

If any of the above information changes, it is the responsibility of the parent/guardian to notify the Health Office.

Parents/ guardians are also advised that in the event of injury, the parent/guardian's personal accident/health insurance carrier, if any, shall provide primary insurance coverage with the school's Pupil Benefits Plan insurance providing secondary and limited coverage.

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