FRONTIER CENTRAL SCHOOL DISTRICT
Enrollment Application & Registration Form

• **Student Information**: _____ □Male □Female Grade _____
Last *First* *Middle*

Child's Date of Birth: ____/____/____ Circle one: Big Tree Blasdell Cloverbank Pinehurst

Mother's Maiden Name: _____

Child's Legal Residence:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

Previous Address: _____
House No. & Street *Apt. No.* *City/town* *Zip code*

If student is ***not*** living with a natural parent (birth parent), state the reason:

_____

_____

Name and phone # of Social Services Caseworker, if any: _____

Name and Address of Each School Previously Attended (including schools of this District, if ever attended):

School Name	Address	Dates Attended	Grades
School Name	Address	Dates Attended	Grades
School Name	Address	Dates Attended	Grades

• **Primary Household Information of Parent/Guardian # 1 (Person Completing this Application)**:
Note: The parent or guardian completing this form must reside in the School District, at the same address indicated above for the student.

_____
First *Middle* *Last*

Employer: _____ Occupation: _____

Relationship to Student: _____ Residing at the same address as the student? □Yes □No

Work Phone:_____ Home Phone: _____ Cell Phone: _____ email address: _____

Current Address:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

□Own □Lease/Rent Length of time living there:_____

If current address is leased or rented, provide full name, address and telephone number(s) of each Landlord:

_____

Most Recent Prior Address:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

□Own □Lease/Rent Length of time living there:_____

• **Information of Parent/Guardian # 2**:

_____
First *Middle* *Last*

Employer: _____ Occupation: _____

Relationship to Student: _____

Work Phone:_____ Home Phone: _____ Cell Phone: _____ email address: _____

Parent/Guardian # 2 resides at same address as Student? □Yes □No (If 'Yes' skip to •Additional Parent/Guardian Information) If 'No', provide current address:

Current Address:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

□ Own □ Lease/Rent Length of time living there:_____

Does this address require student mailings? □Yes □No

Most Recent Prior Address:_____
House No. & Street *Apt. No.* *City/town* *Zip code*

□Own □Lease/Rent Length of time living there:_____

• **Additional Parent/Guardian Information**:

Name of adult who provides health insurance for the child: _____

Name of adult who listed child as a dependent on last year's Federal tax return: _____

Name of adult who will list the child as a dependent on this year's Federal tax return: _____

Student is living with (check only one):

□Both Parents □Mother only □Father only □An Agency □Alone □Guardian(s) □A Spouse/Partner □Foster Parent (DSS-2999)

Joint Custody □ Yes □ No **Note: A copy of most recent court document designating custodial parent/guardian is required.**

If you are not a parent of the child, are you a legal guardian? □ Yes □ No If yes, provide copy of court documents.

If you are not yet a legal guardian, do you plan to file for guardianship? □ Yes □ No

Have both natural parents transferred permanent custody and control of the child to you? □ Yes □ No

Note: The District may require additional written information if the child is not living with either parent.

• **Temporary Living Arrangements**:

The following questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435.
Your answers help determine the services the student may be eligible to receive.

1. Is the child's 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, proceed to question 3:

3. Where is the student presently living? (*Check one box.*)
   □In a motel or shelter
   □With more than one family in a house or apartment
   □Moving from place to place
   □In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

• **Sibling Information**:

NAMES OF BROTHERS & SISTERS OF STUDENT & ALL RESIDENTS	BIRTH DATE mo/day/yr	GENDER	GRADE	CURRENT SCHOOL	SCHOOL FOR COMING YEAR	LIVES AT HOME?
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No
_____	_____	☐M ☐F	_____	_____	_____	☐Yes ☐No

• **Emergency Contact Information**:

1. Name:_____ Phone #s: Daytime:_____ Cell:_____ Evening:_____

Address: _____
House No. & Street *Apt. No.* *City/town* *Zip code*

Relationship to child: _____

2. Name:_____ Phone #s: Daytime:_____ Cell:_____ Evening:_____

Address: _____
House No. & Street *Apt. No.* *City/town* *Zip code*

Relationship to child: _____

• **Proof of Residency Submitted by Parent/Guardian #1** (minimum of two required; attach copies):

1._____ 3._____

2._____ 4._____

Please return all completed forms to:

Frontier Educational Center
Attn: Central Registrar's Office
5120 Orchard Ave.
Hamburg, NY 14075

***<u>Important Notice About the Rights of Non-Custodial Parents</u>**:
Non-custodial parents have a right to participate in their child's school programs and activities and to obtain information about their child's education on the same basis as a custodial parent/guardian of the child. An exception to this general rule is made when the District is provided with a court order that deprives the non-custodial parent of one or more of these rights.

In the absence of being provided with a court order that limits the rights of a non-custodial parent, the District will presume that the non-custodial parent has the right to request information concerning his or her child, and to participate in the child's school programs and activities on the same basis as a custodial parent/guardian of the child.

Are you in possession of a court order that limits a non-custodial parent's access to the child, the child's school programs and activities, or the child's educational records? ☐**Yes** ☐**No**

If you answered Yes, then you must attach a copy of the order to this application.

I understand that with my failure to provide a court document designating custodial parent/guardian, the Frontier Central School District will not be held responsible for releasing my child, _____, to his/her alternate parent.

Signature_____ **Date_____**

If you answered 'No', and you believe that there is a reason why a child's non-custodial parent should *not* have access to the child, the child's school programs and activities, or the child's educational records, then it is your responsibility to apply for an appropriate court order. If you obtain such an order after the date of this application, you must promptly deliver a copy of the court order to the District's Registrar.

FRONTIER CENTRAL SCHOOL DISTRICT
Confidential Medical Form

State Law requires us to have a medical record for each student enrolled in the Frontier Central School District. Please complete both pages. Without the signed Medical Form, children will not be enrolled. A copy of your child's immunization record is also essential for registration.

Child's Legal Name _____ Grade ____ Date of birth:_____

Address: _____ Phone _____
Street City/town Zip

School: _____ Entry Date: _____ Grade: _____

Prior School: _____
Does your child have any **medical problem or physical limitations** that we should know about to best administer to the child? Is so, please EXPLAIN:
_____
It is essential that we know if your child is on any medication. All current medication should be labeled with your child's name, prescription, and instructions and only given to the school nurse upon registration. **MEDICATIONS, including over the counter remedies such as cough drops, pain relievers, etc. are to be kept in the Health Office.** The only exception is emergency medications for diabetes, asthma, anaphylaxis. You must see the school nurse regarding these situations. Completion of proper forms is also required.

Mother:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Father:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Step Parent:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Step Parent:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Guardian:_____Daytime Phone/Cell Phone_____

Address: _____ **E-Mail**_____

Please list two responsible adults with reliable transportation available that the school could contact/release your child to in the event of the parent's absence:

Name: _____ Name_____

Phone #: _____ Phone #: _____

Relationship to child: _____ Relationship to child: _____

Child's MEDICAL PROVIDER _____ Child's DENTIST: _____

Phone # _____ Phone # _____

MEDICAL-SURGICAL RELEASE

In the event of a serious accident or illness, I understand that every effort will be made to contact me if my child needs emergency medical-surgical treatment. However, if it is impractical or impossible to do so, I hereby give permission for my child to be transported to _____ Hospital OR to the nearest Emergency Treatment Center or Hospital to secure proper treatment, as deemed most appropriate by medical personnel. I, the undersigned, do also hereby authorize officials of Frontier Central School District to contact directly the persons named on this form and do authorize the named medical providers to render such treatment as may be deemed necessary in an emergency, for the health of said child.

Parent to Complete **Medical History for:**_____
Child's Legal Name

Does your child have:

☐ Allergies (please specify) Allergic to: ☐ Medication ☐ Bee Stings ☐ Food ☐ Environmental
☐ Other (please specify): _____

☐ Asthma ☐ Diabetes ☐ Ear/Hearing Condition

☐ Fainting Spells ☐ Heart Disease ☐ Eye/Vision Condition

☐ Muscular – skeletal conditions, muscular dystrophy, cerebral palsy, etc.

☐ One of a paired organ (ex: eye, kidney, testicle) please specify: _____

Has your child ever had:

☐ Chickenpox Date: _____ ☐ Head Injury Date: _____

☐ Lead Poisoning Date: _____ ☐ Pneumonia Date: _____

☐ Rheumatic fever Date: _____ ☐ Scarlet Fever Date: _____

☐ Seizures Date: _____ ☐ Other Serious Medical Conditions Date: _____

Please specify type and date for the following if applicable:

☐ Broken Bones _____

☐ Depression, anger, coping, stress problems? _____

Treatment for above _____

☐ Neurological, personality, mental conditions? _____

☐ Serious Injuries: Type: _____ Date: _____

Type: _____ Date: _____

☐ Speech, Physical and/or Occupational Therapy? _____

☐ Learning and/or Reading Difficulties? _____

☐ Surgery (specify type and date) _____

_____

Any other relevant health information _____

_____

_____ _____

*** Signature of Parent/Guardian** **Date**

Please advise us of any changes in these questions so that your child's record will remain current.

Form Revised 7/16

FRONTIER CENTRAL SCHOOL DISTRICT

STUDENT PHYSICAL EXAMINATION

Dear Parent or Guardian,

New York State Education Law mandates that a physical examination on all students who are in the Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade, new entrants, and triennially for students in special education classes. If you prefer to have your own health care provider conduct this examination, please have the NYS School Health Examination Form (included in this packet) completed and returned to school by October 20th. Any health care provider physical completed on or after September 1st of the previous calendar year will be accepted. In accordance with the law, the District nurse practitioner will provide the physical examination for students who do not return the form. A parent or guardian may be present during the examination with advance notification so a time can be arranged.

You will receive a notice if there is any problem identified during your child's physical examination. If notified, please be sure to take your child to his/her health care provider, eye doctor or dentist as soon as possible. Nurses are required to follow up on all referrals sent to you addressing your child. If you would like any assistance in linking with medical providers, health insurance or any other particulars relative to the referral, please do not hesitate to contact your school nurse. If your child requires a modification in the school environment to best meet his/her physical needs, please advise the school nurse as soon as possible. If medications are required during the school day (including those over-the-counter), forms are available from the school nurse that must be completed by the medical provider per the medication administration policy. The medication administration policy can be found in the District calendar or by contacting the building nurse.

SPORTS PHYSICALS

Sports physicals are valid for a period of 12 months. We will accept a physical from your private Physician or Practitioner.

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REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

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

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ 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:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.			**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.

☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.

☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.

☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

FRONTIER CENTRAL SCHOOL DISTRICT

5120 ORCHARD AVENUE
HAMBURG, NY 14075-5657

HOUSING QUESTIONNAIRE

Name of LEA: Frontier Central School District

Name of School: _____

Name of Student: _____

Please complete the following:

Gender: ☐ Male ☐ Female Date of Birth: ____/_____/_____ *Month Day Year* Grade: _____ *(preschool-12)* ID#: _____ *(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 _____

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

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Student Racial and Ethnic Identification

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.

Student Name:_____ Grade:_____

Please answer questions (1) and (2). Please read them before you respond. (For question (1) check the box that best describes your child. Check only ONE box.

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

Select one or more races from the following five racial groups. (For question (2), check all groups that apply to your child. Check at least one box.)

- ☐ AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- ☐ 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 OR AFRICAN AMERICAN: 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_____ Date_____

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FRONTIER CENTRAL SCHOOL DISTRICT STUDENT EMERGENCY CARD

Date _____ **/School Year** _____

School _____

Grade _____

Room No. _____ **/Locker No.** _____

Birthdate _____

Bus No.: To School _____ **To Home** _____

Student's Name _____
Last **First** **Middle**

Male ☐ **Female** ☐

Address _____

City _____ **Zip** _____

Home Telephone _____

To parent or guardian: To serve your child in case of accident or sudden illness, it is necessary that you furnish the following information for emergency calls:

	Name	**Daytime telephone**	**Cell phone**	**Pager**	**E-Mail address**
Mother					
Father					
Step-parent					
Guardian					

CHILD LIVES WITH: (*Please Circle All that Apply*) **Mother Father Step-mother Step-father Guardian other**

Status of Parents: (*Please Check Appropriate Space/s Below*) **List Date:** (*Separated/Divorced/Death*) _____

( ) Married ( ) Separated ( ) Divorced ( ) Mother Remarried ( ) Father Remarried ( ) Mother Deceased ( ) Father Deceased

Legal Custodial Restrictions: ( ) No ( ) Yes _____ *Copy of Legal Document Must be Provided*

Alternate Site for Emergency School Closing (within walking distance of bus stop):

Name _____ Address _____ Phone _____

Name and Birthdates of Brothers & Sisters under 18 years of age:

Name	Birthdate	Name	Birthdate

List two neighbors or NEARBY adults who will assume temporary care of your child if you cannot be reached:

Name _____ Name _____

Address _____ Tel. _____ Address _____ Tel. _____

Relationship _____ Relationship _____

Please Complete This Section

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Severe Allergies	☐	☐	Chronic Conditions	☐	☐
Diabetes	☐	☐	Eye/Ear Problems	☐	☐	Emotional/Behavior Conditions	☐	☐
Epilepsy Seizure	☐	☐	Asthma	☐	☐	Other	☐	☐

Medication _____

If you answer yes to any of the above please explain:

_____

_____

Primary Care Doctor _____ Dentist _____

Telephone Number _____ Telephone Number _____

"I, hereby, give my permission for my child to be transported to _____ Hospital or to the medical facility deemed most appropriate by medical personnel."

1. I, the undersigned, do hereby authorize officials of Frontier School District to contact directly the persons named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child.
2. In the event that physicians, other persons name on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.
3. To best meet health and safety needs of my child, the nurse **may** share relevant health information with appropriate school personnel. This information will be kept confidential.

_____ _____

Student's Last Name **First** **Initial** **Signature of Parent or Guardian**