

Student Residency Questionnaire

Note: The Bethlehem Central School District uses this page to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C.11435. Answers to this residency information help determine the services the student may be eligible to receive. Assistance is provided by our Homeless Liaison, Ms. Jody Monroe. She can be reached at (518) 439-3102 or in the Educational Service Center at 90 Adams Place.

Name of School: _____

Name of Student : _____ Sex: Male
Last First Middle Female

Birth Date ____/____/____ Grade: _____ Student ID #: _____
Month Day Year *(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 eve 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? (*Check one box.*)

- In a motel/hotel
- 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 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**. The district's LEA liaison is required to assist the student obtaining any necessary documents, including immunization or school records after the student has been enrolled.



Bethlehem Central
School District

90 Adams Place
Delmar, New York
12054

(518) 439-7481 ext. 325
Fax (518) 475-0352
<http://bcsd.k12.ny.us>

Central Registrar

Dear Parents:

Welcome to Bethlehem Central School District. Enclosed are the registration forms to be filled out completely and neatly. Along with the forms enclosed, please bring the following items when registering your child, to Central Registration located at 90 Adams Place, Delmar, NY 12054:

- **Three (3) proofs of residency** (see attached for acceptable documents)
- **Original birth certificate (or certified copy) or passport**
- **Current immunization record** (official record signed by physician)
- **Parent/Guardian license or picture ID**
- **Custody papers, if applicable.** (If the student is not the biological child, documentation must be presented which proves a permanent and total transfer of custody and control has been achieved.)

Recent report card, standardized test results, I.E.P, or any other information from the previous school would be helpful.

I look forward to meeting you and if you have any questions, please feel free to call me at 439-7481.

Sincerely,

Melissa Haas,
Central Registrar

THREE (3) PROOFS OF RESIDENCY

Lease Agreement – Legal and valid lease between owner and renter. Agreement must contain property owner's name and signature; name, signature and address of parent/guardian.

Purchase Contract – Purchase contract must contain seller's name, the address of the property being purchased and the purchaser's name.

Utility Bill - Telephone, National Grid, Cable or other service bill. Must contain parent/guardian name and address within the last 30 days.

Homeowner's Insurance Policy- Must be a valid policy with parent/guardian name and address.

Auto Insurance ID Card- must be valid and contain the name and address of parent/guardian.

Recently Issued NYS Driver's License- New York State Driver's License or Learner's Permit containing parent/guardian name and address issued within last 30 days.

Don't Forget to sign-up for SNN



You can sign up for Bethlehem's "School News Notifier" (SNN), by visiting the following Web site at <https://snn.neric.org/bcsd/>.

SNN is an **opt-in** e-mail alert system for which parents and residents can sign up to receive e-mail alerts from the district. With SNN, district officials have the power to send updates and reminders about district activities or information about emergency school closings and delays. Users can choose to receive any or all of the alerts, and they can unsubscribe at any time. **Your e-mail address will be kept confidential. **

(over)



**Bethlehem Central
School District**
Office of the Registrar
90 Adams Place
Delmar, NY 12054
(518) 439-7481
<http://bcscd.k12.ny.us>

For Office Use Only							
Enroll Date _____	Proofs of Residence _____						
Immunization Y or N _____	Birth Certificate Y or N _____	Other _____					
Student ID# _____	Family # _____						
Home School:	CL	EAG	EL	GL	HAM	SL	MS HS

STUDENT ENROLLMENT FORM

The information on this form is very important. **PLEASE PRINT CLEARLY.**

Student Name _____ M or F _____ Grade _____
(Last name, First name, Middle initial) (Circle one)

Preferred Name _____ Date of Birth _____ Home Phone _____

Home Address _____
(Number) (Street) (Town) (Zip Code)

Mailing Address (if different and/or P.O. box) _____

Previous School District Attended: _____

Has your child ever attended a Bethlehem school? YES or NO If Yes, When? _____ Last Grade _____

Name(s) of Brothers and Sisters residing with student: (Attach additional sheet if needed.)

Name (Last, First, Middle initial)	M or F	Birth date (m/d/yy)	Grade	School
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are there any restricted releases for this child? [Documentation required. Please attach.] _____

Parent 1 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address (if different from student) _____

Lives with Student Has Custody of Student Should Receive Student Mailings/BC@Home

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name: _____ Position: _____

Work Address _____

Parent 2 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address (if different from student) _____

Lives with Student Has Custody of Student Should Receive Student Mailings/BC@Home

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name: _____ Position: _____

Work Address _____

If parent / guardian **cannot be reached please contact:** (see backside)

Emergency Contact 1 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address _____

Lives with Student Has Custody of Student Should Receive Student Mailings/BC@Home

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name: _____ Position: _____

Work Address _____

Emergency Contact 2 Name: Dr. / Mr. / Mrs. / Ms. _____
(Last name, First name, Middle initial)

Relationship to student _____

Address _____

Lives with Student Has Custody of Student Should Receive Student Mailings/BC@Home

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name _____ Position: _____

Work Address _____

If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign a consent for the release of special education records so that special education services can begin as soon as possible.

Consent for release of special education records signed?

YES NO

Your answers to the following questions are not used for purposes of determining eligibility to attend the District's schools. Your answers to these questions are necessary for certain programming and data collection purposes.

Birthplace: _____ **Home language:** _____

Ethnic category (check all that apply):

American Indian/Alaskan Native Asian Black/African American

Hispanic Native Hawaiian/Other Pacific Islander White

If born in a foreign country:

Date entered the USA: _____ **Date started in a U.S. School:** _____

Date started in a New York State School: _____

Parent Statement:

I certify the above information is true and correct. Any misinformation regarding residency may result in being billed to cover the cost of instruction and/or exclusion from attending the Bethlehem Central School District.

Parent Signature Date



Bethlehem Central
School District
Office of the Registrar
90 Adams Place
Delmar, NY 12054
(518) 439-7481

PARENT/GUARDIAN HOME LANGUAGE IDENTIFICATION SURVEY

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. We will use these responses to help determine if your child qualifies for our English as a Second Language program. Thank you for your assistance.

Student's Name _____ School _____

1. What is your relationship to the child? Mother Father Guardian

2. What language did the child learn when he/she first began to talk? _____

3. What language does the family speak in the home most of the time? _____

4. What language does the mother speak to the child most of the time? _____

5. What language does the father speak to the child most of the time? _____

6. What language does the child speak to his/her mother most of the time? _____

7. What language does the child speak to his/her father most of the time? _____

8. What language does the child speak to other adults at home most of the time? _____

9. What language does the child speak to his/her brothers and sisters most of the time? _____

10. Would you like an interpreter to assist in future communication with the school? Circle one: **YES** **NO**

Signature of person completing survey

Date

New York State Education Department
Office of Bilingual Education
Albany, NY 12234
www.nysed.gov



Bethlehem Central
 School District
 Office of the Registrar
 90 Adams Place
 Delmar, NY 12054
 (518) 439-7481

REQUIRED IMMUNIZATIONS FORM

Please ask your child's doctor to complete this form and sign below or attach a signed copy of physician immunization record.

Public Health Law 2164 requires that the following immunizations be received prior to the child being allowed to enter school:

- 3 OPV or IPV (polio vaccine).**
- 3 DPT, DTaP, or DT (diphtheria-pertussis-tetanus vaccine). FULL DOSES ONLY.**
- 1 Tdap (Tetanus, Diphtheria, and Pertussis Booster) for all children born on or after 01/01/94 who enroll in sixth grade**
- 1 Measles vaccine (after first birthday).**
- 1 Mumps vaccine (after first birthday).**
- 1 Rubella vaccine (after first birthday).**
- 1 Measles booster (after 15 months) for all children born on or after 01/01/1985.**
- 3 Hepatitis B vaccine for all children born on or after 01/01/1993 and all students entering seventh grade on or after September 2000.**
- 1 Varicella vaccine (after first birthday) for all children born on or after 01/01/1998 and all children born on or after 01/01/1994 who enroll in sixth grade, or physician documentation regarding history of disease.**

The district needs proof of compliance with this law at the time you register your child into the school district. Adequate proof is written certificate or record from the physician's office, a transcript from the previous school, or a certificate of religious or medical exemption.

If the immunizations have not been completed by the date your child is to enter school, **we must exclude the child from school** until the immunizations have been completed or until proof of satisfactory progress toward this completion is shown. Please be advised that the law requires us to exclude children for up to two weeks if the process is not taking place and that, after two weeks of exclusion, we are required to notify Child Protective Services which is a division of the Albany County Department of Social Services.

STUDENT'S NAME _____ Date of Birth _____

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
OPV (3)	_/_/___	_/_/___	_/_/___	_/_/___	
IPV (3)	_/_/___	_/_/___	_/_/___	_/_/___	
DPT,DTaP	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
DT	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
Tdap	_/_/___				
Measles	_/_/___	_/_/___			
Mumps	_/_/___				
Rubella	_/_/___				
MMR	_/_/___	_/_/___			
Hepatitis B	_/_/___	_/_/___	_/_/___		
Varicella	_/_/___				
History of Varicella Disease on		_/_/___			
HIB	_/_/___	_/_/___	_/_/___	_/_/___	
Other	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___

Physician's Signature _____ Date _____

Physician's name or stamp



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PHYSICAL APPRAISAL REPORT
(Required **BEFORE** students enters grades 2, and 4)

Home School (Please circle one) CLK EAG ELS GLE HAM SLI

Student Name _____ Grade _____ M or F (please circle)

Address _____ Town _____ Zip Code _____ Phone _____

Date of Birth _____

Teacher _____

Parent or guardian: Please bring this form to school after completion by your child's physician.

HEALTH HISTORY

- | | | |
|----------------------------|-----------------------------|--------------------------|
| _____ Allergies | _____ Eye Conditions | _____ Scarlet Fever |
| _____ Bee sting | _____ Hearing Problem | _____ Seizures |
| _____ Food | _____ Heart Disease | _____ With fever |
| _____ Other | _____ Hyperkinesis | _____ Without fever |
| _____ Anemia | _____ Kidney Disease | _____ Speech Problem |
| _____ Asthma | _____ Learning Disabilities | _____ Strep Throat |
| _____ Cerebral Palsy | _____ Leukemia | _____ TB |
| _____ Chicken Pox | _____ Measles Disease | _____ Chest X-ray |
| _____ Colds & Sore Throats | _____ Mononucleosis | _____ TB Contact |
| _____ Cystic Fibrosis | _____ Mumps Disease | _____ TB test results |
| _____ Diabetes | _____ Orthopedic Conditions | _____ Urinary Infections |
| _____ Ear Infections | _____ Pneumonia | _____ Vision Problem |
| _____ PE Tubes | _____ Rheumatic Disease | _____ Whooping Cough |
| | _____ Rubella Disease | |

Problems at birth _____

Serious injuries _____

Surgeries _____

Other concerns _____

Please list all over the counter and prescription medications, including dose and frequency: _____

Are there any physical restrictions or limitations for physical education class or other activities in school?

Yes _____ No _____ If yes, list _____

PHYSICAL

Immunizations during past year (List type, month, day, year) _____

Height _____ Weight _____ Body Mass Index _____

Weight Status Category:

- Less than 5th 5th through 49th 50th through 84th 85th through 94th 95th through 98th 99th and higher

Blood Pressure _____ Normal Pulse _____

Eyes (R) _____ (L) _____ Ears (R) _____ (L) _____ Tonsils _____

Teeth _____ Cervical _____ Thyroid _____ Other _____ Heart _____

Lungs _____ Abdomen _____ Hernia _____ Nervous System _____ Posture _____

Orthopedic _____ Scoliosis (see reverse if positive) _____ Feet _____ Skin _____

Genitourinary _____ Urine testing: Sugar _____ Protein _____

Tanner: Male / Female 1 2 3 4 5 Female – Onset Menstruation _____

General Condition _____

Recommendations _____

Physician's Signature _____ **Date of exam** _____

Physician's Name or Stamp _____

Student's name _____ Grade _____ Date of exam _____

Additional health history information: _____

SCOLIOSIS SCREENING

Effective September 1982, New York State Law requires annual scoliosis screening for each child between the ages of 8 and 16.

Please check any positive findings:

- | | | |
|------------------------------|-------|-------|
| 1. Forward bend | | |
| Thoracic prominence | L () | R () |
| Lumbar prominence | L () | R () |
| 2. Shoulder higher | L () | R () |
| 3. Prominent scapula | L () | R () |
| 4. Elevated scapula | L () | R () |
| 5. Iliac crest higher | L () | R () |
| 6. Arm to body space greater | L () | R () |
| 7. Recommendations: | | |

Screened by: _____

Physician's name or stamp: _____



Bethlehem Central
School District
Health Services

Dear Parent or Guardian:

As a part of your child's requirements for school, a physical examination has been required for students in Kindergarten and in Grades 2, 4, 7 and 10. A law was recently enacted that expands health screenings to include the dental health of students in New York State.

After September 1, 2008, when we require that your child have a physical examination, we will be requesting a dental certificate as well. There is a sample certificate available for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse, as it will be filed in your child's Cumulative Health Record.

Thank you for your cooperation in this new health endeavor. Our students' benefit when we work together to promote the health and achievement of all students.

Please call the school's Health Office if you have any questions or concerns.

Bethlehem Central High School
439-4921

Elsmere Elementary School
439-3019

Bethlehem Central Middle School
439-7705

Glenmont Elementary School
434-1246

Clarksville Elementary School
768-8158

Hamagrael Elementary School
439-8889

Eagle Elementary School
694-3953

Slingerlands Elementary School
439-8984

(OVER)

Dental Health Certificate

Parent/Guardian: **NYSED Law 903** (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle		
Birth Date: / / Month Day Year	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
School: Name		Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date _____

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)

Dentist's Signature

--	--

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

- Yes No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.



**Bethlehem Central
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Office of the Registrar
90 Adams Place
Delmar, NY 12054
(518) 439-7481

HEALTH HISTORY FOR NEW ENTRANTS

This form should be completed and signed by the parent or guardian

Home School (*Please circle one*) CLK EAG ELS GLE HAM SLI

Name _____ DOB _____

Family Physician _____ Phone _____

Last visit to M.D. (*date, reason*) _____ Date of last physical _____ Next M.D. visit (*date, reason*) _____

Dentist _____ Phone _____

Pregnancy History (gestational diabetes, bed rest, medication needs)

Labor and Birth History (emergency delivery, premature labor, birth trauma, delayed discharge from hospital): _____

Gestation: _____ Full term _____ Premature Delivery: _____ Normal _____ Cesarean Birth Weight: _____

Growth and Development / Walked at age: _____ Spoke first word at age: _____ Spoke sentences at age: _____

Health History

Serious illness: _____

Serious injury: _____

Surgery: _____

Check if your child has, or has had, any of the following and provide date when appropriate:

- | | | |
|--|-----------------------------|----------------------------|
| _____ Allergies | _____ Ear Infections | _____ Rheumatic Disease |
| _____ Bee sting | _____ History of PE Tubes | _____ Rubella Disease |
| _____ Food | _____ Eye Conditions | _____ Scarlet Fever |
| _____ Medication | _____ Hearing Problem | _____ Seizure Disorder |
| _____ Other | _____ Heart Disease | _____ Speech Problem |
| _____ Anemia | _____ Hypotonia | _____ Strep Throat |
| _____ Asthma | _____ Kidney Disease | _____ TB |
| _____ Cerebral Palsy | _____ Learning Disabilities | _____ Chest X-ray |
| _____ Chicken Pox (<i>documentation</i>) | _____ Leukemia | _____ Urinary Infections |
| _____ Colds & Sore Throats | _____ Measles | _____ Urinary Reflux |
| _____ Convulsions | _____ Mononucleosis | _____ Vision Problem |
| _____ With fever | _____ Mumps | _____ Last Vision Exam: |
| _____ Without fever | _____ Orthopedic Conditions | _____ Vision Specialist: |
| _____ Cystic Fibrosis | _____ Pneumonia | _____ Glasses Worn: YES NO |
| _____ Diabetes | | _____ Whooping Cough |

Current Health Status (Please state if your child is, or has been, under treatment, or taking medication:

Health conditions under treatment: _____

Medical provider(s) providing treatment: _____

Medication(s) Please list all over the counter and prescription medications, including dose and frequency: _____

Will medications need to be given while your child is at school?

_____ Yes _____ Not known at this time

Are the any physical restrictions or limitations for physical education or other activities at school?

_____ Yes _____ No * If restrictions or limitations, M.D. documentation is required

Has your child ever received, or is currently receiving, the following services:

_____ OT _____ PT _____ Speech _____ Other

Parent/Guardian Signature

Date



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EAR HEALTH HISTORY

Child's Name _____ Date of Birth _____ Date _____

Parent/Guardian _____ Child's Age _____

Please help us better understand your child by answering the following questions:

1. Does your child have normal hearing (when ears are clean and healthy)? _____

2. Did your child ever have ear infections? If so, how many total? _____

Between birth to 1 year old _____ 3 to 4 years old _____

1 to 2 years old _____ 4 to 5 years old _____

2 to 3 years old _____ 5+ years old _____

How long did the ear infections last? _____

How often did they re-occur? _____

3. Has your child had myringotomies and PE tubes inserted? _____

If so, how many times and at what ages? _____

4. Has your child ever been seen by an ear, nose, and throat doctor? _____

5. Has your child ever been seen by an audiologist for hearing testing? _____

6. Has your child received speech/language therapy? _____

If so, at what ages and for how long? _____

Therapy was for: _____ articulation _____

language or other _____ (please explain) _____

7. Has your child received amplification during periods of not hearing? _____

8. Is there anything else in your child's ear health history that may be helpful in understanding your child's educational needs?

9. What concerns do you have about your child and school? _____



Bethlehem Central School District
Office of the Registrar
Educational Service Center
90 Adams Place
Delmar, New York 12054
(518) 439-7481
(518) 475-0352 FAX

Date Mailed or Faxed:

Authorization for the Release or Transfer of Information

Student Name: _____

Name and address of school last attended:

School: _____

Address: _____

Phone and /or Fax: _____

The above student has enrolled in our school district. **Please forward all school records including health, psychological, academic and other data.** Thank you for your assistance.

MAIL TO:

Office of Central Registration
90 Adams Place
Delmar, New York 12054
(518) 439-7481
(518) 475-0352 fax

Signature of Parent or Guardian

Date