Millard Fillmore Elementary
Moravia Middle School
Moravia High School
John P. Birmingham, Superintendent
68 South Main Street
Moravia, NY 13118
Phone: 315-497-2670

Welcome to the Moravia School District!

To register your child for enrollment, please return the attached forms along with all required documents.

Grades UPK-5: Elementary School Office – Kristi Rouse, ext. 1005, krouse@moraviaschool.org
Grades 6-8: Middle School Counseling Office – Lisa Torok, ext. 2012, ltorok@moraviaschool.org
Grades 9-12: High School Counseling Office – , ext. 2015,

1. **Completed Registration Packet (9 forms to be completed by parent/guardian)**
    - Student Registration Form
    - Emergency Information Form
    - Verification of Residence (include required document from list as proof)
    - Student Racial and Ethnic Identification
    - Health Registration Form
    - Transportation Request Form
    - Emergent Multilingual Learners Language Profile (UPK Only)
    - Home Language Questionnaire or Cuestionario de Idioma del Hogar (Grades K-12)
    - Migrant Education Program Survey
    - Household Income Eligibility Form

2. **Proof of Age (include one of the following):**
    - Birth Certificate
    - Passport

3. **Proof of Residency (include one of the following):**
    - Deed or Mortgage Statement
    - Lease/Rental Agreement
    - Utility Bill Reflecting Service Address (Electric, Water, Gas, etc.)

4. **Immunization and Health Records (include a copy of the most recent physical dated within the last year)**

5. **If Applicable:**
    - Custody Agreement
    - Proof of Guardianship
    - Form DSS-2999 for Foster Placement
    - Court Order of Protection

Today's Date: __________

STUDENT REGISTRATION
Moravia Central School District

Grade Entering: _____

Sex: M F (Circle One)

Child's Legal Name: ______ *Last* ______ *First* ______ *Middle*

Street Address: ______ *Street* ______ *City* ______ *Zip Code*

Mailing Address: ______ *Include Post Office Box* ______ *City* ______ *Zip Code*

Home Phone #: ______ Child's Cell Phone #: ______

Date of Birth: ______ Place of Birth: ______

Check one: ☐ Parents together ☐ Parents separated

If parents are separated, check one: ☐ Joint Custody ☐ Sole Custody

*Parents/Guardians: please provide proof of custody (ex. court order, parental affidavit, DSS-2999 form for foster placement).

Student lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Legal Guardian ☐ Foster Parents ☐ Other:___________

Restriction of Contact and/or Information: (must provide paperwork)

☐ Order of Protection ☐ Custody restrictions ☐ Restriction of info to non-custodial parent ☐ No restriction for parents/guardians

Is Parent/Guardian currently serving in the military (including guard, reserves, or retired within a year or less)?

☐ **Yes** ☐ **No**

Are you a Migratory Agricultural Worker*? ☐ **Yes** ☐ **No**

A student is a migrant child if the student is, or whose parent, guardian, or spouse is, a migratory agricultural worker, including a migratory worker or a migratory fisher, and who, in the preceding 36 months, in order to obtain, or accompany such parent, guardian, or spouse, in order to obtain temporary or seasonal employment in agricultural or fishing work has moved from one school district to another.

Mothers Name: ______ *Last* ______ *First*

Address (if different): ______ *Street* ______ *City* ______ *Zip Code*

Home Phone: ______ Cell Phone: ______

Email address: ______ Place of Employment: ______

Employer's Address: ______ *Street* ______ *City* ______ *Employer's Phone Number*

Fathers Name: ______ *Last* ______ *First*

Address (if different): ______ *Street* ______ *City* ______ *Zip Code*

Home Phone: ______ Cell Phone: ______

Email address: ______ Place of Employment: ______

Employer's Address: ______ *Street* ______ *City* ______ *Employer's Phone Number*

Step Parent/Other Adult ______ *Last* ______ *First* ______ *Relationship to Child*

Home Phone: ______ Cell Phone: ______

Email address: ______ Place of Employment: ______

Employer's Address: ______ *Street* ______ *City* ______ *Employer's Phone Number*

CHILD'S FORMER SCHOOL: ______________________________
School's Name

School's Address: ______________________ ______________________ __________ __________
Street *City* *State* *Zip Code*

Grade Last Attended: ____________ Phone Number: ______________ Fax Number: ______________

Reason for Transferring: ____

Please check below indicating if your child has received any of the following additional services at their previous school:

_____ IEP / 504 Plan

_____ OT / PT

_____ Speech Therapy

_____ ELL

_____ Math/Reading Support

_____ Psychological Services

_____ Self-contained Special Ed Classroom (15:1:1, 12:1:1, 8:1:1)

PLEASE LIST OTHER CHILDREN AND/OR ADULTS IN HOUSEHOLD:

Child's Name	Birth Date	Grade

Adult's Name	Relationship to child

Emergency Information Form
Moravia Central School

Student name: ____ Grade: ________________

Residence address: ____ Phone: ________________
Mailing address if different: ____________________________________

Please list as many names as applicable in order of call preference.

1st contact: Adult name: _________________________ Relationship to child:____________________

Address if different from child: ____

Home phone: _________________________ Cell phone: __________________ Work: __________________

2nd contact: Adult name: _________________________ Relationship to child:____________________

Address if different from child: ____

Home phone: _________________________ Cell phone: __________________ Work: __________________

3rd contact: Adult name: _________________________ Relationship to child:____________________

Address if different from child: ____

Home phone: _________________________ Cell phone: __________________ Work: __________________

4th contact: Adult name: _________________________ Relationship to child:____________________

Address if different from child: ____

Home phone: _________________________ Cell phone: __________________ Work: __________________

5th contact: Adult name: _________________________ Relationship to child:____________________

Address if different from child: ____

Home phone: _________________________ Cell phone: __________________ Work: __________________

Child care provider:____ Telephone/Cell: _____________________

If your child is seriously injured and school personnel are unable to contact any person on this form, may school personnel have an ambulance transport your child to an emergency center? Yes _____ No _____

Hospital Preference: ____

Parent/Guardian signature: ____

MORAVIA
CENTRAL SCHOOL DISTRICT

VERIFICATION OF RESIDENCE

Student's Name: ____

Physical Address: ____

____

I, ________________________________, hereby affirm that my child resides with me in the Moravia Central School District at the above address. I understand that I must present proof of residency in my name and that I am required by law to immediately notify school officials if there is a change of the above address/residence. I further understand that if I provide false residency information, the school is entitled to recover from me the cost of instruction for the time my child was not authorized to attend school in the district.

____ ____________________________
Signature of Parent/Guardian Date

If the student does not have fixed/adequate housing, where is the student currently living?
(***If applicable***, *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
☐ In a hotel/motel
☐ In a car, park, bus, train, or campsite
☐ Other temporary living situation (Please describe): ____

House Bill 557, effective July 1, 1997, implemented a $500 penalty for those providing false residency information to schools.

Documents must be submitted to verify residence at the address listed above. Acceptable documents are listed below.

Do not write below this line. Office use only.
****

- Deed or Mortgage Statement
- Lease/Rental Agreement
- Utility Bill
- Income tax forms

VERIFICATION: _____ACCEPTED _____DENIED ____
Signature of School Official Date

MORAVIA CENTRAL SCHOOL DISTRICT

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.

Name of School:

School District Student Identification Number:

Date of Birth (Month/Day/Year):
/ /

Student Name: Last, First, Middle:

Grade Level:

DIRECTIONS TO PARENT/GUARDIAN

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.

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** [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.

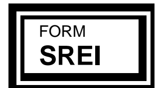
____ Signature of Parent/Guardian/Other

________________________ Date

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): ___________________________

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations.



MORAVIA CENTRAL SCHOOL DISTRICT

STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: The *Moravia Central School District* has adopted a policy which requires the collection and recording of the ethnic identity of students in the *Moravia Central School District* in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the back of this page. Put a check (√) in the box for the category or categories which best describe your child. The *Moravia Central School District* understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: This form will be filed in the student's permanent record as confidential information

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

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

Please complete the form on the reverse side of this page

HEALTH REGISTRATION
Millard Fillmore Elementary

Grade Entering: _____
Sex: M F (Circle One)

Child's Name: ______________ Last ______________ First ______________ Middle
Street Address: ______________ Street ______________ City ______________ Zip Code
Mailing Address: ______________ Include Post Office Box ______________ City ______________ Zip Code
Home Phone #: ______________
Date of Birth: ______________
Mother's Name: ______________ Last ______________ First ______________ Maiden Name
Father's Name: ______________ Last ______________ First

FAMILY PHYSICIAN:

Name: ______________ Phone Number: ______________

MEDICAL HISTORY: *Please indicate if your child has had any of the following. Provide a date if applicable.*

________	Chicken Pox	________	Asthma Inhaler? Y N	________	Diabetes
________	3-Day Measles	________	Allergies Inhaler? Y N	________	Epilepsy
________	Regular Measles	________	Surgery	________	Mumps
________	Serious Injury	________	Heart Conditions	________	Other

Does your child have a vision problem? ______________
Does your child have a hearing problem? ______________
Does your child have a Speech or Language problem? ______________
Does your child have any other medical problems or concerns which we should know about? ______________

Has your child been examined by a specialist? Give name of specialist and year of examination:

	Name	Year(s)		Name	Year(s)
Pediatrician:	________	____	Psychologist:	________	____
Neurologist:	________	____	Psychiatrist:	________	____
Ophthalmologist:	________	____	Speech Clinic:	________	____
Optometrist:	________	____	Other Clinic:	________	____
Dentist:	________	____	Others:	________	____

Is your child on any medication(s): Y N (Circle One)
If Yes, list medication(s): ______________

REMINDER: ***Proof of immunizations and current physical must be furnished before entry of school.***

Health & Immunization Information

Millard Fillmore Elementary School

Updated 03/05/2025

Immunization Requirements

The New York State Department of Health immunization requirements for school attendance in grades UPK-5 are as follows:

1. DtaP: Five (5) doses of Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine **UPK Four (4) doses*
2. IPV: Four (4) doses of Polio vaccine **UPK Three (3) doses*
3. HEPB: Three (3) doses of Hepatitis B vaccine **UPK Three (3 doses)*
4. MMR: Two (2) doses of Measles, Mumps, and Rubella vaccine **UPK One (1) dose*
5. VZR: Two (2) doses of Varicella (Chickenpox) vaccine **UPK One (1) dose*

The only exemptions are medical exemptions. New York law does not recognize non-medical exemptions. Medical exemption as defined in PHL § 2164 is as follows:

“If any physician licensed to practice medicine in this state certifies that such immunization may be detrimental to a child's health, the requirements of this section shall be inapplicable until such immunization is found no longer to be detrimental to the child's health.”

The Cayuga County Health Department holds immunization clinics at their offices located at 8 Dill Street, Auburn, NY 13021. Call (315)253-1560 for an appointment. Be sure to bring your child’s prior immunization records.

Physical Exam Requirements

According to the New York State Education Law, Section 904, a child will not be allowed to participate in physical education activities until a physical exam is provided. The exam must be on the required state form, signed by a medical provider, and dated within one calendar year prior to the first day of school. Physical exams are required for school entry; and for grades K, 1, 3, 5, 7, and 11. The nurse’s office is open during summer months. The fax number is (315)649-7346.

Medication Requirements

To administer any medication, the school nurse must receive a physician’s order (including the name of the student, the medication, the dosage, the route, the frequency, and the indication). Medication orders are effective for the school year. Signed parental consent is also required. The medication must be delivered to the nurse in the original pharmacy labeled bottle. Over-the-counter medications must be in new, unopened containers. Medication must be brought in by an adult and picked up at the end of the year by an adult.

Dental Requirements

Dental exams/treatment records are requested, but not required, to attend school. Dental health assessments can determine if there is a problem that may interfere with the student's ability to chew, speak, or concentrate in class.

Health Concerns

Please keep the school nurse updated in regards to your child's health status; such as surgeries, medication changes, illnesses/diseases, or other conditions that may affect your child's academic performance or needs while at school.

Please report any visits to urgent care or the emergency room.

Documentation of injury/illness is required if the student is to be excluded/excused from PE class and/or recess.

Please keep the school updated with current emergency contact names and phone numbers. This information is important if a child is ill and needs to go home or if there is an emergency.

MORAVIA
CENTRAL SCHOOL DISTRICT

Jerrica Schillawski, RN
Heather Edwards, LPN
Middle/High School Nurse's Office
68 South Main Street
P.O. Box 1189
Moravia, NY 13118
Phone: 315-497-2670 x2029

Sarah Shaw, RN
Heather Edwards, LPN
Elementary School Nurse's office
24 South Main Street
P.O. Box 1189
Moravia, NY 13118
Phone: 315-497-2670 x 1125

Provider's Order for Medication at School

Student's Name:____ **DOB:**________________

Diagnosis:____

Name of Medication:_____________________________________

Dosage:____________________

Route:______________________

Time(s)/Frequency To Be Given:___________________________

Physician Signature:____________________________________

Date order is effective (Valid for 1 School Year):_________________

Health Care Provider Permission for Independent Carry and Use (Rescue medications only)

I attest that this student has demonstrated to me that he or she can self-administer the medication listed above (pertains only to inhaled respiratory rescue medication, epinephrine auto-injector, insulin, or other medications/supplies that require rapid administration) safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school/school-sponsored activity. Staff intervention and support are needed only during an emergency.

Physician signature: ___________________________

Date:________________

Parent Permission to Administer Medication at School:

I request the school nurse administer medication as ordered by the provider. I agree that if the nurse determines my student can take their own medications, trained staff may assist my student in taking their own medications. I will provide the medication in the original pharmacy or over-the-counter container. I understand that if I do not pick up/coordinate these medications within 2 weeks of the last day of school, they will be disposed of by nursing staff and not stored over the summer.

I agree that (if permitted by the provider) my student can use their rescue medication effectively and may carry and use this medication independently at any school/school-sponsored activity. Staff intervention and support are needed only during an emergency. I also understand that only *rescue* medications can be carried and used independently by my student.

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**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ Yes ☐ 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	Date
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 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/		☐
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: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for 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, 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 ONLY 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

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use 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: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ 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/ Dental Hygienist

I. The dental health condition of ______________________________ _______ on__________ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist'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):____

II. 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.

Transportation Request Form
Moravia Central School District

The completion of this form will provide us the information needed to plan for your child's busing needs and to plan our routes. If busing is needed someone from the transportation department will contact you with pick up and drop off details. If you have any questions please contact us at 315-497-2670 Ext. 3001. Please remember that students in third grade or lower must have an adult or older sibling present at drop off location.

Grade Entering:____ Date of Birth: ________________________________

Child's Name ______________________________ ______________________________
Last First

Is bus transportation needed from HOME in the morning? **______Yes** **_______No**

Is bus transportation needed to HOME in the afternoon? **______Yes** **_______No**

Home Address ____

____

Contact Name ______________________________ ______________________________
Last First

Contact Numbers ______________________________ ______________________________
Home Cellphone

If your child will be at a CHILD CARE provider please fill out this information

My child will be at a child care provider's house: _____Before school ____After school ___Both

Child Care Name ____

Child Care Number ____

Child Care Address ____

____

Special Notes ____

List other children in household who will also need transportation:

Name	Grade

For office use only: Route #AM ______________________

Parent Transport __________ Route #PM ______________________

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students[i]

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other _______________

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?
17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure If yes, in what language(s)? 17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure If yes, in what language(s)?
18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no If yes, in what language(s)?
19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no If so, what goals do they describe?
20. Please describe anything special you did to prepare your child to begin Prekindergarten.

[i] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.

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:**
		❑ Male ❑ Female
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE ______________

Language Background
(Please check all that apply.)

Question				
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 ________ *specify*	❑ Parent 2 ________ *specify*	❑ Guardian(s) ________ *specify*	
4. What language(s) does your child understand?	❑ English	❑ Other	________ *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	________ *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	________ *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	________ *specify*	❑ Does not write

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? ______________________________

______________________________ Month: Day: Year: ______________________________

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:

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)

☐ Work related to logging, harvesting, or initial processing of trees.

☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answered YES, please provide your contact information below:

Parent/Guardian Name: ____

Home address: ____

Telephone number: (_______)-________-_________ Best time to be reached: _________ AM/PM

Previous Address: ____

Student name: ______________________________ Age ______________Grade__________

Student name: ______________________________ Age ______________Grade__________

To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Acta de Educación Elemental y Secundaria (ESEA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito en la escuela, excursiones, programa de verano, actividades de envolvimiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o algún miembro de su familia ha trabajado o buscado trabajo en algunas de las siguientes ocupaciones en los pasados 3 años?

☐ Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)

☐ Trabajando en la cultivación o procesamiento de los árboles.

☐ Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.

Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: ____

Dirección Física: ____

Teléfono: (_____)-_______-________ Mejor tiempo para ser contactado __________ AM/PM

Dirección anterior: ____

Nombre del estudiante: _____________________________ Edad___________ Grado__________

Nombre del estudiante: _____________________________ Edad___________ Grado__________

Para someter este referido, por favor envíelo por fax a 607-436-3606, o por correo a NYS Migrant Education Program- Identification & Recruitment Office 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020

Community Eligibility Provision (CEP)/Provision 2 non-base year
Household Income Eligibility Form

Moravia Central School District is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. **All children in the school will receive meals/milk at no charge** regardless of household income or completion of this form. **This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for (ie. Free testing/band instrument).** Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call 315-497-2670 x2033, if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: ____ CASE #_________________________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐
	$ ________ / ________	$ ________ / ________	$ ________ / ________	$ ________ / ______	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: ____________________________________ Date**:** ____________ Email Address: ____

Home Phone: ____ Work Phone: ____

Home Address: ____

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

___SNAP/TANF/Foster
___ Income Total Household Income/How Often: __________________________/_________________________ Household Size: _________

_____Free Eligibility _____Reduced Eligibility ________Denied Eligibility

Signature of Reviewing Official ____ Date______________________

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1 — **ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.**

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2 — **HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.**

(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 4**. SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4 — **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.

Nondiscrimination Statement:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or

2. **fax:**
   (833) 256-1665 or (202) 690-7442; or

3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.