

Fort Ann Central School District



STUDENT ENROLLMENT PACKET

Required Forms and Documentation for Enrollment

- Registration Form
- 2 Proofs of Residency** (*see enclosed list*)
- Migrant Services Screening Form
- Digital Equity Survey
- Student Health History Form
- Health Records/Immunizations/Dental Records
- Proof of Student's Identity (*birth certificate, passport, baptism certificate*)
- Copy of Parent/Guardian's Photo ID
- Copy of IEP or 504 Plan (*if applicable*)
- Transportation Form (*PreKindergarten enrollments do not need to complete*)
- Custody Papers (*if applicable*) **legal guardians MUST provide court order**
- Free and Reduced School Meals Application (*if included*)

Please return registration packet to:

Mrs. Krista Crosbie
Registrar/Guidance Secretary
1 Catherine Street
Fort Ann, NY 12827
518.639.5594 ext. 52101
Fax: 518.639.4341
kcrosbie@fortannschool.org

Fort Ann Elementary School

One Catherine Street
Fort Ann, NY 12827

Phone 518-639-5594 Fax 518-639-4341



Acceptable Proof of Residency

Please submit **2** documents from the list below

Category A:

- **Lease agreement or notarized statement from landlord** - must include tenants' names and physical address AND BE SIGNED
- **Copy of deed**
- **Voter registration card**
- **Auto insurance card/policy** - policy must be active
- **Homeowner's insurance policy** - must include name and full physical address of parent/guardian- must be active
- **Income Tax Form** - most recent year
- **School Tax bill** - most recent year
- **Mortgage Statement or other documents from your closing**
- **Pay Stub*** - must include name and full physical address of parent/guardian
- **Utility Bill*** - National Grid, Local water/sewer, cable
- **Notices/Award Letters from DSS, OTDA, SSA***

Category B:

Accepted only if none of the above are available and with approval of the District:

- Notarized statement from a third party - must include all tenants' names and the full physical address as well as the date tenancy began
- Copy of proof of purchase contract with a letter from an attorney listing the expected closing date/time

*Proof of Residency with * must be within 30 days of receipt by district.

Mrs. Crosbie
Registrar/Guidance Secretary
(518)639-5594 ext. 52101
Fax (518)639-4341
kcrosbie@fortannschool.org

Emergency Contacts: Name a responsible party other than a parent or guardian who will be able to pick up your child from school if needed (i.e. illness, injury, discipline reasons, unexpected school closure, etc.), and we are unable to reach a parent or guardian. Emergency contacts will need to bring their photo identification with them when picking up a student.

Name	Relationship	Daytime Address	Home, Cell, or Work Phone Number(s)

Other Siblings or Children in the Household

Name	Date of Birth	Lives in Household?	School Attending	Grade	Relationship to Student being enrolled

Has your child received any of the following services? AIS Math AIS ELA Bilingual Education Special Education Services

Does your child have a 504 Plan? Yes No If yes, please supply a copy of the most recent 504 Plan.

My child has been identified for Special Education Services and is receiving or has received: (Please supply a copy of your child's IEP)

Special Class (i.e. 15:1:1; 4:1:2) Consultant Teacher Services Resource Room Occupational Therapy
 Counseling Services Physical Therapy Speech Therapy/Services Other: _____

Has your child ever been evaluated or referred for evaluation to determine eligibility for Special Education programs/services? Yes No
 If yes, please list the type of evaluation, date, and who provided the evaluation. Please provide copies of the reports, if available.

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, school meals, and other services. If you check any box other than In Permanent Housing, please contact Mrs. Crosbie (518.639.5594, ext. 52101 or kcrosbie@fortannschool.org), or the District's McKinney-Vento Liaisons: Mr. Hoskins (518.639.5594, ext. 52050 or jhoskins@fortannschool.org), or Mrs. Discenza (518.639.5594, ext. 52100 or mdiscenza@fortannschool.org) as soon as convenient; your child may be eligible to be enrolled without further documentation.

Where is the student currently living?

- 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

Is there any other information you would like us to know or we need to know about your child?

Please return all the required enrollment forms in this packet, and return to Mrs. Crosbie, Registrar, at the Fort Ann Central School District, 1 Catherine Str, Fort Ann, NY 12827. The District is unable to request school records from your child's previous school until you have submitted the completed forms, 2 proofs of residency (see enclosed list), and your child's birth certificate or passport. If you are unable to supply the proof of residency or your child's birth certificate, please contact Mrs. Crosbie at 518.639.5594. Ext. 52101 or kcrosbie@fortannschool.org to discuss possible alternatives.

Information on Rights of Parents from the Family Education Rights and Privacy Act (FERPA)

An educational agency or institution shall give full rights under the Act of either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation or custody that specifically revokes these rights. (Authority: 20 U.S.C.1232g)

Signature of Parent or Guardian: _____

Date: _____

FORT ANN CENTRAL SCHOOL DISTRICT

Request for Student Records

Date of Request: _____

Originating School or Institution

Name of Previous School or Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Student's Information

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Grade Level: _____

Date of Last Attendance: _____

Signature of Parent/Guardian (if available): _____

The following records are hereby requested:

- | | |
|--|--|
| <input type="checkbox"/> Transcripts or report cards | <input type="checkbox"/> Discipline records |
| <input type="checkbox"/> Test data / standardized test scores | <input type="checkbox"/> Immunization records |
| <input type="checkbox"/> English Language (ELL) test score (if applicable) | <input type="checkbox"/> Health / medical records |
| <input type="checkbox"/> List of courses and grades at time of withdrawal | <input type="checkbox"/> Sports physical documentation |
| <input type="checkbox"/> Attendance records | <input type="checkbox"/> Psychological records |
| <input type="checkbox"/> Individual Literacy Plan (if applicable) | <input type="checkbox"/> Sociological records |
| <input type="checkbox"/> IEP (Individual Education Plan) if applicable | <input type="checkbox"/> Copy of birth certificate |
| <input type="checkbox"/> 504 Plan (if applicable) | <input type="checkbox"/> Other _____ |

Signature of Requesting School Representative:

Signature

Title

Date

PLEASE MAIL TO:

Mrs. Krista Crosbie, Guidance/Registration Secretary
Fort Ann Central School District
1 Catherine Street
Fort Ann, NY 12827
(518)639-5594, ext. 52101
Fax: (518)639-4341
kcrosbie@fortannschool.org

Eligibility Screen for Migrant Education Services

*** Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency assistance and referrals to other services as needed. ***

Has your family moved to a different school district in the last 3 years? YES _____ NO _____

In the last three years, **has the parent or guardian** of the child enrolling **done farm work as a paid job?** (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES _____ NO _____

If yes, what farm did you work on? _____ Where? _____ When? _____



If you can answer **YES** to **BOTH** of the above questions, your family **MAY** qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Parents/ Guardians

Mother's name _____ Father's Name _____

Home Address _____ Home Phone # _____
(Street Address)

(city, town or village) (Zip) _____ Work or Message # _____

School District _____ School Building _____

School Contact Person _____ Contact Number _____

Other Useful information (directions, farm names, best time to contact, etc.) _____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. For more information please call the Migrant Program at (315) 867-2079.

Thank you for your assistance.

Cuestionario de Elegibilidad para Servicios de Educación Migrante

*** Servicios del Programa de Educación Migrante son gratuitos y pueden incluir tutoría, ayuda con necesidades de salud, viajes educacionales, programas del verano, actividades de involucrar a los padres, educación para adultos, ayuda de emergencia y referidos a otros servicios como necesario. ***

¿Ha mudado su familia a un distrito escolar diferente en los últimos 3 años? Sí _____ NO _____

¿En los últimos 3 años ha trabajado un padre o guardián en granja como: lechería, plantando, cosechando frutas o legumbres, el procesamiento o empacar de comida, corta de árboles o cultivo de árboles? Si _____ NO _____

Si UD dijo que si, ¿en que granja? _____ ¿Donde? _____ ¿Cuándo? _____



Si Usted contestó que **Sí** a **AMBOS** preguntas de arriba, su familia **PUEDE** calificar para servicios de Educación Migrante. Para estar contactado por una reclutadora del Programa de Educación Migrante, favor de llenar la información de abajo.

Nombre del niño(a) _____ Fecha de Nacimiento _____ Grado _____

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Nombre del niño(a) _____ Fecha de Nacimiento _____ Grado _____

Nombre del niño(a) _____ Fecha de Nacimiento _____ Grado _____

Padres/ Guardianes

Nombre de la Mamá _____ Nombre del Papá _____

Dirección de la Casa _____ Numero de teléfono en casa _____
(Dirección de la Calle)

_____ # de teléfono del trabajo o de Mensaje _____
(Ciudad o Pueblo) (Código Postal)

Distrito escolar _____ edificio escolar _____

Persona para contactar _____ numero para contactar _____

Otra información Útil (direcciones, nombres de granjas, mejor hora de llamar, etc.) _____

Para someter este referido, favor de mandarlo por fax al Herkimer BOCES a
(315) 867-2087 o mandar por correo al dirección de arriba.
Para más información, favor de llamar al Programa Migrante a (315) 867-2079. Gracias.

FORT ANN CENTRAL SCHOOL DISTRICT



DIGITAL EQUITY SURVEY

The New York State Education Department is asking parents and guardians to complete the Digital Equity Survey for each student in their family in grades Kindergarten - Grade 12. This survey will provide information on student access to devices and internet access at their residences. This data will be used to help educators better serve students and families. **Please answer each question below**, and follow any additional instructions provided for submitting or returning the survey.

Child's Name: _____ Grade: _____

1. What device will your child use to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student will most often use to complete their schoolwork.)

Desktop Computer

Laptop

Tablet

Chromebook

Smartphone

No Device

2. Who is the provider for the device in question #1?

School

Personal Device

3. Is the primary learning device identified in questions #1 shared with anyone else in the household?

Shared

Not Shared

4. Is the primary learning device sufficient for your child to fully participate in all learning activities away from school?

Yes

No

5. Is your child able to access the internet in their primary place of residence?

Yes

No

6. What is the primary type of internet service used in your child's primary place of residence?

Residential Broadband

Cellular

Mobile Hotspot

Dial Up

DSL

Community WiFi

No Service

Satellite

Other: _____

7. In your primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?

Yes

No

8. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

Cost

Availability

None

Other: _____

Please complete one form for each student in your household

**22/23 FORT ANN CENTRAL SCHOOL
TRANSPORTATION INFORMATION FORM**

FORT ANN SCHOOL DISTRICT TRANSPORTATION POLICY

1. Students who are in Kindergarten **MUST** be met by their parent/guardian, if a parent/guardian is not there to meet their child, they will be taken back to school.
2. Transportation information forms must be completed every school year, even if the information is the same as the previous year.
3. Transportation information forms should be completed anytime there is a change in your child's bus route.

NOTE: ANY CHANGES TO BUS ROUTE MUST BE FILLED OUT PRIOR TO THE CHANGE. PLEASE ALLOW FOR 3 TO 5 DAYS FOR PROCESSING.

Today's Date _____ Effective Date _____

Student's Name _____ Grade _____

Parent/Guardian Name _____

Primary Home Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

PLEASE CHECK IF YOUR CHILD IS A WALKER OR PARENT DROP OFF/PICK UP _____ AM _____ PM

STUDENT DRIVES SELF _____

AM Alternate Bus Route:

Name Child Care Provider: _____ Phone: _____

Address: _____

Please **circle** which days your child(ren) will be PICKED UP at child care:

MON TUES WED THURS FRI

PM Alternate Bus Route:

Name Child Care Provider: _____ Phone: _____

Address: _____

Please **circle** which days your child(ren) will be DROPPED OFF at child care:

MON TUES WED THURS FRI

Parent/Guardian Signature _____

FORT ANN CENTRAL SCHOOL DISTRICT

STUDENT HEALTH HISTORY

Student Name:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Date of Birth:	Age:
Parent/Guardian: (person completing form)	Grade:

Has your child ever:	YES	NO	If yes, please explain and include date
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had surgery/been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone or muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out or fainted	<input type="checkbox"/>	<input type="checkbox"/>	
Had a concussion or head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Worn glasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	
Used hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	
Had braces, spacers or other orthodontics	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD

- | | | |
|---|--|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> OCD/ODD | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Skin Conditions | |
| <input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle) | <input type="checkbox"/> Other: _____ | |

Please indicate:	YES	NO	Please specify:
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____ Severity: <input type="checkbox"/> mild <input type="checkbox"/> severe
Medication at <u>Home</u>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____ Dose: _____
Medication at <u>School</u>	<input type="checkbox"/>	<input type="checkbox"/>	Name: _____ Dose: _____
Dietary Concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gluten Free <input type="checkbox"/> Lactose Free Other: _____

Any additional health concerns: _____

Parent/Guardian Signature: _____ Date: _____

Dental Health Certificate- Optional

Parent/Guardian: New York State law (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: / / Sex: Male Will this be your child's first visit to a dentist? Yes No
Month Day Year Female

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

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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 1/2 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.