

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://bcasd.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 _____ Phone _____

Date of Birth _____ Birthplace _____

Date entered USA, if born in foreign country _____ U.S. Citizen: YES or NO

Home Language _____ Date started in a USA School: _____

Ethnic Category (choose one): White American Indian/Alaskan Native Asian
Black/African American (Non-Hispanic) Hispanic/Latino Multi-Racial Pacific Islander

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

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

Previous School District Attended: _____

Previous School Address: _____

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

Grade _____ Which School: _____

Name(s) of Brothers and Sisters (Attach additional sheet if needed.)

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

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

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

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

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

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name: _____ Position: _____

Work Address _____

If parent / guardian cannot be reached:

.....
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

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

Home Phone _____ Work Phone _____ Cell Phone _____

Employer's Name _____ Position: _____

Work Address _____

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

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 Disease on		_/_/___	
HIB	_/_/___	_/_/___	_/_/___	_/_/___	
Other	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___

Physician's Signature _____ **Date** _____

Physician's name or stamp



Bethlehem Central High School
 700 Delaware Ave.
 Delmar, NY 12054
 (518) 439-4921

Bethlehem Central Middle School
 332 Kenwood Ave.
 Delmar, NY 12054
 (518) 439-7460

FOR: Grades 7 and 10 Physical
 Entering Students
 Interscholastic Sports
 Working Certificate

PHYSICAL APPRAISAL REPORT

SPORT: _____

Student Name _____ Grade _____ Homeroom _____ Gender: M or F
 Address _____ Date of Birth _____

HEALTH HISTORY

To be completed by physician. Physicians please answer YES or NO. Use reverse side to explain YES answers.

Heart Disease _____	Hernia _____	Fracture _____
Kidney Disease _____	Bleeding Disorder _____	Dislocation _____
Lung Disease _____	Allergy _____	Operation _____
Need For Medication _____	Congenital Defects _____	

PHYSICAL

Immunizations during past year (list type and date given) _____

Height _____ Weight _____ Eyes (R) _____ (L) _____ Ears (R) _____ (L) _____ Blood Pressure _____ Pulse _____ Teeth _____ Gums _____ Tonsils _____ Glands: Cervical _____ Thyroid _____ Other (Specify) _____ Cardiac: Upright _____ Supine _____ Femoral Pulses _____	Body Mass Index _____ <u>Weight Status Category (BMI Percentile)</u> <input type="checkbox"/> Less than 5th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher Nervous System (specify if Epilepsy) _____ Skin _____ Body Habitus _____ Abdomen _____ Orthopedic: Structural Defect _____ Scoliosis (See Reverse If Positive) _____ Feet _____ Lungs _____ Speech _____ Hernia _____ Tanner: Male/Female 1 2 3 4 5 Female – Onset Menstruation _____
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This certifies that the above named student is physically qualified to participate in the following categories of competition during the school year 20____ – 20_____

Check the boxes for the category in which an athlete may qualify:

Contact or Collision Sports
 Football/Baseball/Basketball
 Soccer/Field Hockey/Ice Hockey/Diving
 Wrestling/Lacrosse/Softball
 Volleyball/Cheerleading/Gymnastics

Endurance Activities
 Swimming/Tennis
 Cross Country/Track and Field

Others
 Bowling/Golf

Reason For Disqualification: _____

Date of Physical: _____ Examiner's Signature: _____

Physician's Stamp

Reviewed and approved for sports _____ School Physician, Date _____

Student Name _____ Date _____

Additional health history information: _____

Article 19 Section 905 of the New York State Education Law requires annual scoliosis screening for each child between the ages 8 and 16.

Please check for 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:

Physician's Signature: _____

Print Physician's Name: _____



**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: 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: / / 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

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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 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 High School
 700 Delaware Ave.
 Delmar, NY 12054
 (518) 439-4921

Bethlehem Central Middle School
 332 Kenwood Ave.
 Delmar, NY 12054
 (518) 439-7460

Home School
(please circle one):
 Middle School or High School

HEALTH HISTORY FOR NEW ENTRANTS

Name _____ Sex _____ Grade _____
 Address _____ Home Phone _____
 Date of Birth _____ Place of Birth _____
 Family Physician _____ Physician Phone _____
 Dentist _____ Dentist Phone _____
 Last Visit to Dentist _____

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

_____ Allergies	_____ Ear Infections	_____ Pneumonia
_____ Bee Sting	_____ PE Tubes	_____ Rheumatic Fever
_____ Food	_____ Eye Condition	_____ Rubella Disease
_____ Anemia	_____ German Measles	_____ Scarlet Fever
_____ Asthma	_____ Hearing Problems	_____ Speech Problems
_____ Cerebral Palsy	_____ Heart Disease	_____ Strep Throat
_____ Chicken Pox	_____ Hyperkinesis	_____ TB
_____ Frequent Colds & Sore Throats	_____ Kidney Disease	_____ Chest X-ray
_____ Convulsions	_____ Learning Disabilities	_____ TB Contact
_____ With Fever	_____ Leukemia	_____ TB Test Results
_____ Without Fever	_____ Measles Disease	_____ Urinary Infections
_____ Cystic Fibrosis	_____ Mononucleosis	_____ Vision Problems
_____ Diabetes	_____ Mumps Disease	_____ Whooping Cough
	_____ Orthopedic Conditions	

Describe _____

Birth Problems (explain) _____
 Serious injuries _____
 Surgeries _____

Special considerations in school:

A) Daily Medication _____

 B) Physical Handicap _____

 C) Special Handling in an Emergency _____

 Any other problems or conditions that the school should be aware of _____

_____ *Date*

_____ *Signature of Parent or Guardian*



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
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