Lansing Central School District

284 Ridge Road, Lansing, NY 14882 607-533-3020 x 4412

Welcome Families! 2018/2019
Kindergarten Registration Packet

PARENTS/GUARDIANS, PLEASE PRESENT THE FOLLOWING DOCUMENTS TO THE REGISTRAR:

- **Completed Registration Packet**

- **Proof of Age** (**ONE** of the following)
  - Original Birth Certificate
  - Passport and/or VISA
  - Baptismal Certificate with date of birth indicated

- **Proof of Residency in the Lansing Central School District** (**TWO** of the following)
  - Contract to purchase a primary residence*
  - Contract to build a primary residence*
  - Certificate of occupancy
  - Lease agreement
  - Utility bill or statement of service (only one utility bill will be accepted)
  - Driver's license
  - Paycheck stub
  - Voter registration card
  - School tax bill
  - Moving company receipt

  *District Policy states that you must reside in the district within 90 days

- **Immunization & Health Records** Include a copy of the most recent physical and immunizations (dated within the last year at the time of registration)

- IF APPLICABLE:
- **Legal Documents**
  - Custody agreement
  - Court Order of Protection
  - Form DSS-2999 for foster placement

- **Student Name Changes** Provide proof of name change (must have two: adoption certificate, court order, social security card, health insurance card)

Please direct any questions regarding the registration process to the district registrar at x4412

Lansing Central School District

KINDERGARTEN STUDENT QUESTIONNAIRE

Student's Name ______________________________ Date of birth________________________

Please help our teachers get to know your student a little better.

1. Has your child been to preschool or in a day care with other children? Where?

2. Is your child able to play by themselves?

3. What does your child enjoy doing? What makes them happy?

4. What activities does your child like to do alone? With others?

5. How does your child get along with friends/siblings?

6. How does your child react to frustration or anger?

7. How does your child respond when hurt or upset?

8. Does your child have any fears or phobias?

9. Is your child fully potty trained? Do they use the bathroom independently?

10. Describe your child's self help skills (getting dressed, tying shoes, personal care, etc.)

11. Has your child ever received special services?

12. Does your child have any gross motor (running, hopping, etc.) or fine motor (writing, cutting, etc.) challenges?

13. Please share anything else you would like us to know about your child:

THANK YOU FOR SHARING THIS INFORMATION. WE LOOK FORWARD TO WATCHING YOUR STUDENT LEARN AND GROW!

Lansing Central School District
Student Registration

ID# ______________________

Date Received : ______________

(OFFICE USE)

Grade ________ Age ________ Date of Birth ____________________ Gender □ Male □ Female

____ ____

Student Legal Name Last First Middle Birthplace City State Country

____

Home Address Street City State ZIP

Student resides with □ Both Parents □ One Parent
□ Legal Guardian

Transferring from District/School

____

____

If parents do not reside in same household, please check.
Custody is □ Sole □ Joint
□ Court ProtectionOrder

Last Day Attended ____________ Grade Completed _______

Has your child ever attended Lansing Schools in the past? □ Yes □ No If yes, please provide dates/grades: ____________________

Primary Parent/Guardian *(residing with student)*

Name ____ Employer ______________________________________

Active Duty Military Personnel □ Yes □ No

Phone # Priority 1 __________________________ (Home, Cell, Work)
Priority 2 __________________________ (Home, Cell, Work)
Priority 3 __________________________ (Home, Cell, Work)

Email ______________________________________
Relationship to student □ Mother □ Father □ Step-parent
□ Legal Guardian □ Other __________________________

Secondary Parent/Guardian *(residing with student)*

Name ____ Employer ______________________________________

Active Duty Military Personnel □ Yes □ No

Phone # Priority 1 __________________________ (Home, Cell, Work)
Priority 2 __________________________ (Home, Cell, Work)
Priority 3 __________________________ (Home, Cell, Work)

Email ______________________________________
Relationship to student □ Mother □ Father □ Step-parent
□ Legal Guardian □ Other __________________________

Lansing Central School Policy states both parents have equal access to their children and school records. If access is denied, court papers must be on file with the District giving specific instructions regarding custody of student and access to records. Complete information for both parents is required if Joint Custody exists or there are no court documents.

Parent not Residing with Student

Name ____ Employer ______________________________________

____

Address Street City State ZIP

Receive Mail □ Yes □ No Active Duty Military Personnel □ Yes □ No

Phone # Priority 1 __________________________ (Home, Cell, Work)
Priority 2 __________________________ (Home, Cell, Work)
Priority 3 __________________________ (Home, Cell, Work)

Email ______________________________________
Relationship to student □ Mother □ Father □ Step-parent
□ Legal Guardian □ Other __________________________

Lansing Central School District
Student Registration

Student's Name ______________________

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 student Hispanic, Latino, or of Spanish origin? A person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. ☐ **YES, Hispanic** ☐ **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 maintain tribal affiliation or community attachment

☐ **Asian:** A person having origins in any of the original peoples of Far East, Southeast Asia, or Indian subcontinent (i.e. Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands,Thailand or Vietnam)

☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Island

☐ **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

Siblings residing with student at same address:

Grade	Name	Sex	Birth date
______	______ Last ______ First ______ MI	______	______
______	______ Last ______ First ______ MI	______	______
______	______ Last ______ First ______ MI	______	______
______	______ Last ______ First ______ MI	______	______

Will your child require English as Second Language Services? ☐ **Yes** ☐ **No Please complete the Home Language Questionnaire**

If yes, please provide the following information: Parent/Guardian is Migrant Worker ☐ **Yes** ☐ **No**

What is the primary language spoken at home? ______________ What language does your child primarily speak? ______________

Is your child **currently** receiving English as a Second Language services? ☐ **Yes** ☐ **No**

Foster Care Placement Please provide the **Form DSS-2999** at time of registration along with the following information:

Name of Case Worker ______________________ Phone ______________

Is this student considered Neglected / Delinquent? ☐ **Yes** ☐ **No**

Parent / Guardian Statement

I understand that proof of New York State required immunizations for polio, mumps, measles, diphtheria, hepatitis, and rubella from a physician or clinic is required for admission to school. If there is a medical or religious exemption, statements of such must be presented. Failure to file either proof of immunization or exemptions will result in the exclusion of the pupil until such time as an appropriate immunization statement is submitted.

Permission is hereby granted to Lansing Central Schools to obtain all heath and scholastic records from the above listed school as well as transfer records to a new school in the event of a move to another district or state. I understand that all reports and screening test results will be treated confidentially; and certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.

Signature ______________________ **Date** ______________

Lansing Central School District

Student Registration

Student's Name ______________________

Authorized Emergency Contacts (in addition to student's parents/guardians)

Name ______________________

Address ______________________
Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ______________________

Address ______________________
Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ______________________

Address ______________________
Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ______________________

Address ______________________
Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Name ______________________

Address ______________________
Street City State ZIP

Phone # Priority 1 ____________ (Home, Cell, Work) Priority 3 ____________ (Home, Cell, Work)
Priority 2 ____________ (Home, Cell, Work) **Relationship to student:** ____________

Lansing Central School District
Student Registration

Student's Name ______________________

Date of Birth: ______________________

Additional Services Information

Is your child currently receiving ***Section 504 Support Services*** (Accommodation Plan)? ☐ **YES** ☐ **NO**

Does your child have an ***Individualized Education Program*** (IEP)? ☐ **YES** ☐ **NO**

Is your child currently receiving ***Academic Intervention Services*** (AIS)? ☐ **YES** ☐ **NO**

If **yes**, please indicate which subject area: ☐ **Math** ☐ **ELA**

Residency Information

The answer you provide below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed; such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In permanent housing
- ☐ In a shelter
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ With another family or person due to loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ Other temporary living situation *(please describe)* ______________________

Parent/Guardian Signature ______________________ Date ______________________

Lansing Central School District

TRANSPORTATION DEPARTMENT
Phone 607-533-4608

STUDENT TRANSPORTATION REQUEST FORM 2018-2019

Student Information:

Child's Name________________________________ Grade______________

Parent/Guardian Information and student's HOME Address:

Name________________________________ Phone ______________

Address________________________________ Phone ______________

DAILY TRANSPORTATION Please indicate your student's needs below

Morning				Afternoon			
Monday:	Home	Day Care	No Pick-up	**Monday:**	Home	Day Care	No Drop-off
Tuesday:	Home	Day Care	No Pick-up	**Tuesday:**	Home	Day Care	No Drop-off
Wednesday:	Home	Day Care	No Pick-up	**Wednesday:**	Home	Day Care	No Drop-off
Thursday:	Home	Day Care	No Pick-up	**Thursday:**	Home	Day Care	No Drop-off
Friday:	Home	Day Care	No Pick-up	**Friday:**	Home	Day Care	No Drop-off

Daycare (including SACCP After-school Program) or alternate location information (must be within district boundaries)

Name________________________________ Phone ______________

Address________________________________ Phone ______________

If transportation is not needed, name of the person who will be picking up the student ______________

EMERGENCY Closing Location Students MUST ride a bus in the event of an emergency dismissal

Name________________________________ Phone ______________

Address________________________________ Phone ______________

PLANNED Early Dismissal Information: ☐ **Adult picking up** OR ☐ **Bus dropping off** (please check one) ☐ **SACCP**

Name________________________________ Phone ______________

Address________________________________ Phone ______________

Lansing Central School District will be responsible for providing transportation for students between school and either their home or the identified alternate day care provider ONLY. For emergency changes in pick-up or drop-off locations, please contact the appropriate school office. **Please note if you have changed addresses within the school district you have 10 business days to complete the change of address form and bring in new proof of residency or we will no longer provide transportation for your student(s).**

CERTIFICATION: I have read and understand the policies and procedures as stated above and consent to having my child transported as I have indicated on this form for the duration of the school year. If I wish to make adjustments to this schedule, I will resubmit this Student Transportation form no less than 2 days prior to the requested transportation schedule change.

Parent's Signature ________________________________ **Date** ______________

Lansing Central School District

HEALTH HISTORY FORM

(To be completed by the parent or guardian)

Name____Date________________________

Date of Birth______________Age_______Sex_______Grade______Primary Care Physician:______________________________________

Medications and Allergies: Please list <u>all</u> of the **prescription and over-the-counter** medicines and supplements (herbal and nutritional) that you are currently taking

____

____

Do you have any allergies? ☐Yes ☐No If yes, please identify specific allergy: ☐ Medicine ☐ Pollens ☐ Food ☐ Stinging Insect

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports/activity for any reason?		
2. Do you have any ongoing medical conditions? If so, please identity below: ☐Asthma ☐Anemia ☐Diabetes ☐Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐High blood pressure ☐ A heart murmur ☐High cholesterol ☐A heart infection ☐Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	*	
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?	**	
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	**	
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes, vision, ears or hearing?		
44. Have you had any eye injuries?		
45. Do you wear glasses, contact lenses, or hearing aid? (please circle)		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here –use the back if necessary

* If yes to #13, is your physician aware and recommending any limitations in activity?

____

** If yes to #34 or 35, was the concussion evaluated by a physician and were you cleared by a physician?

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of parent/guardian____Date__________

Adapted from the ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. HE0503 9.268110410

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

I certify that to the best of my knowledge my answers are complete and true.

Parent/Guardian Signature: ______________________________ Date__________________

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment 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 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.

Lansing Central School District Media Release Form

2018-2019
AUTHORIZATION AND RELEASE FOR PUBLICATION OF STUDENT WORK AND STUDENT PHOTOGRAPHIC/VIDEO IMAGES

Dear Parents/Guardians/Eligible Students:

We are proud of our students and the work that they create throughout the school year. Such work includes, by way of example, writings, artwork, photographic/video/digital images, and instrumental and vocal recordings. We like to showcase our students and their work beyond the classroom and school buildings through publication in a variety of calendars, the district, school and classroom websites, and local and national newspapers, television stations, and radio broadcasts.

Please complete and return the attached form to your child's teacher/ school as soon as possible so we can understand your wishes with regard to publication of your child's work and/or photographic and video image.

Thank you for your cooperation.

□ **Yes – I hereby consent.** I grant permission for my child to participate and appear in audio recordings, films, photographs, written articles, or on websites and social media sites. This consent includes the use of my child's image, voice, and name in media projects by LCSD to print, broadcast or Internet media outlets, such as Newspapers, radio, television, and websites.

As authorized above, I hereby release, discharge and hold the School District and its representatives harmless from any and all claims that may arise by reason of the publication of such works and/or images.

□ **No – I do not consent.** I do not grant permission for my child to participate and appear in audio recordings, films, photographs, written articles, or on websites and social media sites. This consent includes the use of my child's image, voice, and name in media projects by LCSD to print, broadcast or Internet media outlets, such as Newspapers, radio, television, and websites.

Child's Name ____ Grade ____________

Parent/Guardian Name ____

Parent/Guardian Signature ______________________________________ Date ____________

Note: for eligible students (i.e., those who are 18 or older), the right to consent or withhold permission for publication is yours. References to "my child" refer to you, the student, directly and you should check your preferences above and then sign in the Parent/Guardian sections provided.

Failure to return this form grants permission to use student work/ images/ recordings as noted above.