Welcome Families! 2019/2020 School Year 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
  - Baptism 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. Also include a health history form (included in the packet).

- **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 or LDavis@LCSD.K12.NY.U.S
Lansing Central School District
Student Registration

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 Protection Order

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 ____________________________

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

Employer ________________________

Active Duty Military Personnel □ Yes □ No

Email ____________________________

Relationship to student □ Mother □ Father □ Step-parent
□ Legal Guardian □ Other ________________________

Secondary Parent/Guardian (residing with student)

Name ____________________________

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

Employer ________________________

Active Duty Military Personnel □ Yes □ No

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 ____________________________

Address Street

City State ZIP

Receive Mail □ Yes □ No

In Case of Emergency can this person be contacted □ Yes □ No

□ Only if all other contacts can not be reached

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 ________________________
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

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Siblings residing with student at same address:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Name</th>
<th>Sex</th>
<th>Birth date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last</td>
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<tr>
<td></td>
<td>Last</td>
<td>First</td>
<td>MI</td>
</tr>
</tbody>
</table>

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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

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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 health 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)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Street</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Phone # Priority 1       |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |
| Priority 2               |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |

| Phone # Priority 1       |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |
| Priority 2               |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |

| Relationship to student:|         |      |       |     |

<table>
<thead>
<tr>
<th>Name</th>
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<th>ZIP</th>
</tr>
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</tr>
</tbody>
</table>

| Phone # Priority 1       |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |
| Priority 2               |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |

| Phone # Priority 1       |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |
| Priority 2               |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |

| Relationship to student:|         |      |       |     |

<table>
<thead>
<tr>
<th>Name</th>
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<td></td>
</tr>
</tbody>
</table>

| Phone # Priority 1       |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |
| Priority 2               |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |

| Phone # Priority 1       |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |
| Priority 2               |         |      |       |     |
| (Home, Cell, Work)      |         |      |       |     |

| Relationship to student:|         |      |       |     |
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 2019-2020

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

<table>
<thead>
<tr>
<th>Day</th>
<th>Morning</th>
<th>Afternoon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Home</td>
<td>Day Care</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Home</td>
<td>Day Care</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Home</td>
<td>Day Care</td>
</tr>
<tr>
<td>Thursday</td>
<td>Home</td>
<td>Day Care</td>
</tr>
<tr>
<td>Friday</td>
<td>Home</td>
<td>Day Care</td>
</tr>
</tbody>
</table>

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 Media Release Form

2019-2020
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/imagesRecordings as noted above.
Required Health Paperwork for Registration

Parents/Guardians are required to provide the following health paperwork:

- **Health History completed**
- **Physical exam by a NYS provider** (within the past year)-must be provided by the 30th day of school.
- **Complete immunization record**-student must be fully immunized by the 14 day of school or the student will be excluded.

If any of the above health paperwork is not provided at the time of registration, the parent/guardian **must** contact the building school nurse.

**School Nurse contact information is below:**

**Sandy Koch, RN BSN**  
Elementary School Nurse  
P: (607) 533-3020 Ext. 1113  
F: (607) 533-4829

**Kelly Bell, RN BSN**  
Elementary School Nurse  
P: (607) 533-3020 Ext. 1113  
F: (607) 533-4829

**Diane Marabella, RN BSN**  
Middle School Nurse  
P: (607) 533-3020 Ext. 2140  
F: (607) 533-4851

**Tracie Larkin RN**  
High School Nurse  
P: (607) 533-3020 Ext. 3111  
F: (607) 533-3456

Please feel free to have your healthcare provider fax the recent physical exam and immunizations to the school nurse, **but you must follow up with the nurse** to ensure the required paperwork was receive. Contact the building nurse with any questions or concerns.

Thank you
2019-20 School Year
New York State Immunization Requirements
for School Entrance/Attendance

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 11, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grade 12 except for interval between measles vaccine doses. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the Immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Prekindergarten (Day Care, Head Start, Nursery or Pre-k)</th>
<th>Kindergarten and Grades 1, 2, 3, 4 and 5</th>
<th>Grades 6, 7, 8, 9, 10 and 11</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine</td>
<td>4 doses</td>
<td>5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older</td>
<td>3 doses</td>
<td></td>
</tr>
<tr>
<td>(DTaP/DTP/Td/Pt/Td)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine</td>
<td>Not applicable</td>
<td></td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>booster (TdP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)</td>
<td>3 doses</td>
<td>4 doses or 3 doses if the 3rd dose was received at 4 years or older</td>
<td>4 doses or 3 doses if the 3rd dose was received at 4 years or older</td>
<td>3 doses</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella vaccine (MMR)</td>
<td>1 dose</td>
<td></td>
<td>2 doses</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>3 doses</td>
<td>3 doses</td>
<td>3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox) vaccine</td>
<td>1 dose</td>
<td>2 doses</td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>Meningococcal conjugate vaccine (MenACWY)</td>
<td></td>
<td></td>
<td>Grades 7, 8, 9 and 10: 1 dose if the dose was received at 16 years or older</td>
<td></td>
</tr>
<tr>
<td>Haemophilus Influenza type b conjugate vaccine (Hib)</td>
<td>1 to 4 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate vaccine (PCV)</td>
<td>1 to 4 doses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday.
   b. If the fourth dose of DTaP was administered at 4 years or older, the fifth (booster) dose of DTaP vaccine is not needed, and a single dose of tetanus toxoid is acceptable for the child.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series if additional doses are needed, use Td vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older. A Tdap vaccine (for incorrectly administered DTaP vaccine) received at 7 years or older will meet the 6th grade Tdap requirement.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap. A dose received at 7 years or older will meet this requirement.
   b. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose of IPV series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. Intervals between the doses of polio vaccine do not need to be reviewed for grade 12 in the 2019-20 school year.
   e. If both OPV and IPV were administered as part of a series, the total number of doses and intervals between doses is the same as that recommended for the U.S. IPV schedule. If only IPV is administered, and all doses were given before age 4 years, 1 dose of IPV should be given at 4 years or older and at least 6 months after the last IPV dose.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten and grade 12. Two doses are required for grades kindergarten through 11.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 6 weeks (8 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks.
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 12 years, the recommended minimum interval between doses is 3 months if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid; for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine. (Minimum age: 6 weeks)
   a. One dose of meningococcal conjugate vaccine (Menactra or Menveo) is required for students entering grades 7, 8, 9 and 10.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 months)
    a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
    b. Unvaccinated children ages 7 through 11 months of age are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
    c. Unvaccinated ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
    d. If one dose of vaccine was received at 24 months or older, no further doses are required.
    e. For further information, refer to the PCV chart available in the School Survey Instructions Booklet at: www.health.ny.gov/prevention/immunization/schools
# Lansing Central School District

## HEALTH HISTORY FORM

*(To be completed by the parent or guardian)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Sex</th>
<th>Grade</th>
<th>Primary Care Physician:</th>
</tr>
</thead>
</table>

## Medications and Allergies

Please list all 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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>MEDICAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sport/activities for any reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify: □ Asthma □ Anemia □ Diabetes □ Infections Other:</td>
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<tr>
<td>3. Have you ever spent the night in the hospital?</td>
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<td>4. Have you ever had surgery?</td>
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<tr>
<td>5. Have you ever passed out or nearly passed out DURING or AFTER exercise?</td>
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<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
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<tr>
<td>7. Does your heart rate race or skip beats (irregular beats) during exercise?</td>
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<tr>
<td>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 □ Heart infection □ Kawasaki disease Other:</td>
<td></td>
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<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG/ECG, echocardiogram)</td>
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<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
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<tr>
<td>11. Have you ever had an unexplained seizure?</td>
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<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
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</tbody>
</table>

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 30 (including drowning, unexplained car accident, or sudden infant death syndrome)?*</td>
<td></td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, or other inherited heart diseases such as long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?</td>
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</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
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<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
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</table>

### BONE AND JOINT QUESTIONS

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
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<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
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<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
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<tr>
<td>20. Have you ever had a stress fracture?</td>
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<tr>
<td>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)?</td>
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<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
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<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
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<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
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<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
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</tbody>
</table>

### FEMALES ONLY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>26. Are you menstruating?</td>
<td></td>
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<tr>
<td>27. Are you pregnant or nursing?</td>
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<tr>
<td>28. Are you taking birth control pills, injectables, or implants?</td>
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<tr>
<td>29. Are you on thyroid medication?</td>
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<td>30. Are you on any medications that affect your menstrual cycle?</td>
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<td>31. Have you ever had any abnormal Pap tests/colposcopies/cystoscopies/dilatation and curettages?</td>
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<td>32. Have you ever had any breast surgeries?</td>
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<tr>
<td>33. Are you on hormone replacement therapy?</td>
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</tbody>
</table>

### Explain "yes" answers here — use the back if necessary

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

** If yes to questions 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: ____________
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: _______________
2019-2020 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete only one form for your household, sign your name and return it to the address listed below. Call Sandi Swearingen, 533-3020 ext.3119 if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: Lansing Central School
284 Ridge Road
Lansing, NY 14882
Attn: Sandi Swearingen

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

<table>
<thead>
<tr>
<th>Student Name</th>
<th>School</th>
<th>Grade/Teacher</th>
<th>Foster Child</th>
<th>Homeless Migrant, Runaway</th>
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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 4, and sign the application.

Name: ___________________________ CASE #: ___________________________

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

<table>
<thead>
<tr>
<th>Name of household member</th>
<th>Earnings from work before deductions Amount / How Often</th>
<th>Child Support, Alimony Amount / How Often</th>
<th>Pensions, Retirement Payments Amount / How Often</th>
<th>Other Income, Social Security Amount / How Often</th>
<th>No Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>I do not have a SS#</td>
</tr>
<tr>
<td></td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
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<td>$ _____ / _____</td>
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<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
<td>$ _____ / _____</td>
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</tbody>
</table>

Total Household Members (Children and Adults)  __ ___

*Last Four Digits of Social Security Number: XXX-XX- __ ___

When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# " before the application can be approved.

1. Signature: An adult household member must sign this application before it can be approved, 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 will get federal funds; the school officials may verify the information and if I purposefully give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: ___________________________ Date: ____________

Home Address: ___________________________ Work Phone: ____________

1. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

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 Household: Total Household Income/How Often: __________________ / ____________
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid

Signature of Reviewing Official ___________________________ Date Notice Sent: ____________
APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to _______. If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: _______. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

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

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

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

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3  ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related or unrelated people 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.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs PART 4 if Part 3 is completed. If the adult does not have a social security number, check the box. If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children’s Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Supplemental Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office. Write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.
NEW YORK STATE MIGRANT EDUCATION PROGRAM
IDENTIFICATION & RECRUITMENT OFFICE
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 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 answer 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 by mail to NYS Migrant Education Program-
Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.