Welcome Families! 2020/2021 School Year
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). 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.US
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

Transferring from District/School

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

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

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
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:

<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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</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
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<tr>
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<tr>
<td>Phone # Priority 1 (Home, Cell, Work)</td>
<td>Priority 3 (Home, Cell, Work)</td>
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<tr>
<td>Priority 2 (Home, Cell, Work)</td>
<td>Relationship to student:</td>
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<tr>
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<td>Relationship to student:</td>
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<td></td>
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<td>Phone # Priority 1 (Home, Cell, Work)</td>
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<td>Priority 2 (Home, Cell, Work)</td>
<td>Relationship to student:</td>
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<tr>
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<td>Priority 3 (Home, Cell, Work)</td>
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<td></td>
</tr>
<tr>
<td>Priority 2 (Home, Cell, Work)</td>
<td>Relationship to student:</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
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 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 2020-2021

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>Morning</th>
<th>Monday:</th>
<th>Tuesday:</th>
<th>Wednesday:</th>
<th>Thursday:</th>
<th>Friday:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
</tr>
<tr>
<td>No Pick-up</td>
<td>No Pick-up</td>
<td>No Pick-up</td>
<td>No Pick-up</td>
<td>No Pick-up</td>
<td>No Pick-up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Afternoon</th>
<th>Monday:</th>
<th>Tuesday:</th>
<th>Wednesday:</th>
<th>Thursday:</th>
<th>Friday:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
<td>Day Care</td>
</tr>
<tr>
<td>No Drop-off</td>
<td>No Drop-off</td>
<td>No Drop-off</td>
<td>No Drop-off</td>
<td>No Drop-off</td>
<td>No Drop-off</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 __________
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
**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 all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Do you have any allergies?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please identify specific allergy:</td>
<td>Medicine</td>
<td>Pollens</td>
</tr>
</tbody>
</table>

**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>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>Has a doctor ever denied or restricted your participation in sports/activity for any reason?</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>Do you have any ongoing medical conditions? If so, please identify below:</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Have you ever spent the night in the hospital?</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Have you ever had surgery?</td>
</tr>
</tbody>
</table>

### HEART HEALTH QUESTIONS ABOUT YOU

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Have you ever passed out or nearly passed out DURING or AFTER exercise?</td>
</tr>
<tr>
<td>6.</td>
<td>Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
</tr>
<tr>
<td>7.</td>
<td>Does your heart ever race or skip beats (irregular beats) during exercise?</td>
</tr>
<tr>
<td>8.</td>
<td>Has a doctor ever told you that you have any heart problems? If so, check all that apply:</td>
</tr>
<tr>
<td>9.</td>
<td>Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</td>
</tr>
<tr>
<td>10.</td>
<td>Do you get lightheaded or feel more short of breath than expected during exercise?</td>
</tr>
<tr>
<td>11.</td>
<td>Have you ever had an unexplained seizure?</td>
</tr>
<tr>
<td>12.</td>
<td>Do you get more tired or short of breath more quickly than your friends during exercise?</td>
</tr>
</tbody>
</table>

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>Any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexpected car accident, or sudden infant death syndrome)?</td>
</tr>
<tr>
<td>14.</td>
<td>Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, or any other inherited heart condition?</td>
</tr>
<tr>
<td>15.</td>
<td>Does anyone in your family have a heart problem, pacemaker, or implantable defibrillator?</td>
</tr>
<tr>
<td>16.</td>
<td>Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
</tr>
</tbody>
</table>

### BONE AND JOINT QUESTIONS

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
</tr>
<tr>
<td>18.</td>
<td>Have you ever had any broken or fractured bones or dislocated joints?</td>
</tr>
<tr>
<td>19.</td>
<td>Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
</tr>
<tr>
<td>20.</td>
<td>Have you ever had a stress fracture?</td>
</tr>
<tr>
<td>21.</td>
<td>Have you ever been told that you have or you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)</td>
</tr>
<tr>
<td>22.</td>
<td>Do you regularly use a brace, orthotics, or other assistive device?</td>
</tr>
<tr>
<td>23.</td>
<td>Do you have a bone, muscle, or joint injury that bothers you?</td>
</tr>
<tr>
<td>24.</td>
<td>Do any of your joints become painful, swollen, feel warm, or look red?</td>
</tr>
<tr>
<td>25.</td>
<td>Do you have any history of juvenile arthritis or connective tissue disease?</td>
</tr>
</tbody>
</table>

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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):

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

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

Parent/Guardian Signature: ________________________________________________ Date________________
# 2019-20 School Year
New York State Immunization Requirements for School Entrance/Attendance¹

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 (DTaP/DTP/Tdap/Td)²</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>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)³</td>
<td>Not applicable</td>
<td>1 dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio vaccine (IPV/OPV)⁴</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)⁵</td>
<td>1 dose</td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B vaccine⁶</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) vaccine⁷</td>
<td>1 dose</td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal conjugate vaccine (MenACWY)⁸</td>
<td>Not applicable</td>
<td></td>
<td>Grades 7, 8, 9 and 10: 1 dose</td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b conjugate vaccine (Hib)⁹</td>
<td>1 to 4 doses</td>
<td></td>
<td>2 doses or 1 dose if the dose was received at 16 years or older</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate vaccine (PCV)¹⁰</td>
<td>1 to 4 doses</td>
<td></td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

¹ Source: New York State Department of Health

² For children receiving DTaP, the fifth dose is recommended at 6 to 18 months of age

³ For children receiving Tdap, the first dose is recommended at 11 through 15 years of age

⁴ Polio vaccine is recommended at 18 months of age or older, or 4 years of age or older

⁵ MMR vaccine is recommended at 12 through 15 months of age

⁶ Hepatitis B vaccine is recommended at birth, 2 months of age, and 6 months of age

⁷ Varicella vaccine is recommended at 12 through 15 months of age

⁸ Meningococcal conjugate vaccine is recommended at 11 through 15 years of age

⁹ Haemophilus influenzae type b conjugate vaccine is recommended at 2 months of age and 4 months of age

¹⁰ Pneumococcal Conjugate vaccine is recommended at 6 through 11 months of age
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. 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 toxins 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 required.
   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 (or 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 in the 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 OPV was 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 OPV 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 (4 weeks) 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 any time thereafter. Dose 2 must be given at least 4 weeks (28 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 13 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 ACP 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 weeks)
    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 ACP 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 children 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 Instruction Booklet at www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization
Lansing Central School District Media Release Form

2020-2021
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.)
Home Language Questionnaire (HLQ)

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 in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

<table>
<thead>
<tr>
<th>STUDENT NAME:</th>
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<tbody>
<tr>
<td>First</td>
<td>Middle</td>
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<tr>
<th>DATE OF BIRTH:</th>
<th>GENDER:</th>
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<tbody>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
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<td>☐ Male</td>
<td>☐ Female</td>
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<tr>
<th>PARENT/PERSOIN IN PARENTAL RELATION INFO:</th>
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<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
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Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?
   - English
   - Other

2. What was the first language your child learned?
   - English
   - Other

3. What is the Home Language of each parent/guardian?
   - Mother
   - Father
   - Guardian(s)

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

5. What language(s) does your child speak?
   - English
   - Other
   - Does not speak

6. What language(s) does your child read?
   - English
   - Other
   - Does not read

7. What language(s) does your child write?
   - English
   - Other
   - Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

<table>
<thead>
<tr>
<th>SCHOOL DISTRICT INFORMATION:</th>
<th>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Name (Number) &amp; School</td>
<td>Address</td>
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ENGLISH
Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school ____________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.
   - Yes* □ No □ Not sure □
   *If yes, please explain: __________________

10a. Has your child ever been referred for a special education evaluation in the past? □ No □ Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?
   - No □ Yes – Type of services received: __________________

   Age at which services received (Please check all that apply):
   □ Birth to 3 years (Early Intervention) □ 3 to 5 years (Special Education) □ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? □ No □ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.) __________________

12. In what language(s) would you like to receive information from the school? __________________

___________________________________________  __________________________  __________________________
Signature of Parent or of Person in Parental Relation  Month:  Day:  Year:  Date

Relationship to student: □ Mother □ Father □ Other: __________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: ______________________________  POSITION: ______________________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: ______________________________  POSITION: ______________________________

ORAL INTERVIEW NECESSARY: □ No □ Yes

**DATE OF INDIVIDUAL INTERVIEW: ______________________________

OUTCOME OF INDIVIDUAL INTERVIEW: □ ADMINISTER NYSITELL  □ ADMINISTER NYSITELL

DATE OF NYSITELL ADMINISTRATION: ______________________________

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

POSSIBILITY LEVEL ACHIEVED ON NYSITELL: □ ENTERING □ EMERGING □ TRANSITIONING □ EXPANDING □ COMMANDING

DATE OF NYSITELL ADMINISTRATION: ______________________________

ENGLISH
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.