Lansing Central School District

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

Welcome Families! 2024/2025
Pre-K and 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

- **Home Language Questionnaire** Please complete the questionnaire in its entirety. Forms in other languages are available upon request.

- **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 x4000

Lansing Central School District

PreK & 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 Father & Mother □ Mother Only □ Father Only □ Legal Guardian

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

Transferring from District/School _____

Last Day Attended _____ Grade Completed _____

Primary Parent/Guardian *(residing with student)*

Name _____ Employer _____

Phone # Priority 1 _____ (Home, Cell, Work) Email _____
Priority 2 _____ (Home, Cell, Work) Relationship to student □ Mother □ Father □ Step-parent
Priority 3 _____ (Home, Cell, Work) □ Legal Guardian □ Other _____

Secondary Parent/Guardian *(residing with student)*

Name _____ Employer _____

Phone # Priority 1 _____ (Home, Cell, Work) Email _____
Priority 2 _____ (Home, Cell, Work) Relationship to student □ Mother □ Father □ Step-parent
Priority 3 _____ (Home, Cell, Work) □ 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

Phone # Priority 1 _____ (Home, Cell, Work) Email _____
Priority 2 _____ (Home, Cell, Work) Relationship to student □ Mother □ Father □ Step-parent
Priority 3 _____ (Home, Cell, Work) □ Legal Guardian □ Other _____

Can he/she receive report cards and other correspondence? □ Yes □ No

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

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

Will your child require English as Second Language Services? □ **Yes** □ **No**

If yes, please provide the following information: Parent 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**

Number of years child has attended US schools _____ Immigration Date _____

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**

Siblings residing with student at same address:

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

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) **Email** ______________

Priority 2 ______________ (Home, Cell, Work)

Priority 3 ______________ (Home, Cell, Work) **Relationship to student:** ______________

Name ______________________

Address Street ______________________ City ______ State ______ ZIP ______

Phone # Priority 1 ______________ (Home, Cell, Work) **Email** ______________

Priority 2 ______________ (Home, Cell, Work)

Priority 3 ______________ (Home, Cell, Work) **Relationship to student:** ______________

Name ______________________

Address Street ______________________ City ______ State ______ ZIP ______

Phone # Priority 1 ______________ (Home, Cell, Work) **Email** ______________

Priority 2 ______________ (Home, Cell, Work)

Priority 3 ______________ (Home, Cell, Work) **Relationship to student:** ______________

Name ______________________

Address Street ______________________ City ______ State ______ ZIP ______

Phone # Priority 1 ______________ (Home, Cell, Work) **Email** ______________

Priority 2 ______________ (Home, Cell, Work)

Priority 3 ______________ (Home, Cell, Work) **Relationship to student:** ______________

Name ______________________

Address Street ______________________ City ______ State ______ ZIP ______

Phone # Priority 1 ______________ (Home, Cell, Work) **Email** ______________

Priority 2 ______________ (Home, Cell, Work)

Priority 3 ______________ (Home, Cell, Work) **Relationship to student:** ______________

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

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.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other *specify*	
2. What was the first language your child learned?	❑ English	❑ Other *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	❑ Guardian(s) *specify*
4. What language(s) does your child understand?	❑ English	❑ Other *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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: _____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

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? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation *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: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

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**

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

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

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

If your child **is** currently receiving Special Education services through an IEP, please check off below which service areas he/she is receiving at this time:

- □ Consultant Teacher Services
- □ Speech/Language Therapy
- □ Physical Therapy
- □ Medical Alerts
- □ Special Education (Special Class, 12:1:1, 15:1:1, Inclusion, BOCES, etc.)*
- □ Resource Room Services
- □ Occupational Therapy
- □ Counseling on IEP
- □ Special Transportation Services (lift bus, bus attendant, etc.)
- □ Out-of-state Pupil Screening Required

**If this box is checked, please note an interim placement procedure will be followed for this student.*

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 2024-2025

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

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 LCSD 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)

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.

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 Interval Health History

Student Name:	DOB:
School Name:	Age:
Grade (check): ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12	Limitations: ☐ NO ☐ YES
Sport	Date of last Health Exam:
Sport Level: ☐ Modified ☐ Fresh ☐ JV ☐ Varsity	Date form completed:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	**NO**	**YES**
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
BRAIN/HEAD INJURY HISTORY	**NO**	**YES**
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

DOES OR HAS YOUR CHILD		
BREATHING	**NO**	**YES**
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
DIGESTIVE (GI) HEALTH	**NO**	**YES**
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

DOES OR HAS YOUR CHILD		
HEART HEALTH		
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness, during or after exercise?	☐	☐
Chest pain, tightness, or pressure during or after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐
Ever been told by a health care provider they have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness or Pain
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ New fast or slow heart rate
- ☐ Heart infection
- ☐ Heart Murmur
- ☐ Low Blood Pressure
- ☐ Kawasaki Disease
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Has a pacemaker
- ☐ Other:

DOES OR HAS YOUR CHILD		
FEMALES ONLY	**NO**	**YES**
Have regular periods?	☐	☐
MALES ONLY	**NO**	**YES**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
SKIN HEALTH	**NO**	**YES**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

FAMILY HEART HEALTH HISTORY

A relative has/had any of the following:

Check all that apply:

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems, long or short QT interval?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?

If you answered **NO** to ***all*** questions, **STOP**. Sign and date below.
GO to page 3 if you answered **YES** to a question.

Parent/Guardian Signature:	Date:

If you answered **YES** to any questions give details. Sign and date below.

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

2024-2025
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.

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.