Cambridge Central School District

Achieving Excellence

District Use Only:

Student ID #: _____

Homeroom #: _____ Teacher: _____

Student's Name: _____ **Date of Birth:** _____ **Gender:** _____ **Grade:** _____

Physical Address: _____
Street City County ZIP Code

Mailing Address: _____
(if different than Physical Address) Street or PO Box City County ZIP Code

Phone Number: _____ **email address:** _____ **Language Spoken at Home:** _____

Place of Birth _____
City County State ZIP CODE

Ethnicity:

__ American Indian __ Hispanic/Latino __ Asian
__ Black/African American __ Pacific Islander/Native Hawaiian __ White __ Other

Special Accommodations: _____ Individualized Education Plan (IEP) _____ 504 Plan ____ No accommodations under IDEA

Parent/Legal Guardian Information:

Parent/Guardian Name: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____ email: _____
Relationship: _____
Physical Address: _____
Street City County ZIP Code

Parent/Guardian Name: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____ email: _____
Relationship: _____
Physical Address: _____
Street City County ZIP Code

Cambridge CSD Registration Form

Order of Protection: yes/no (If an order of protection exists, it must be submitted to the building principal at the time of enrollment.)
Are both parents living at home? yes/no
Who has legal custody: _____ (please provide custody/guardianship papers to the district)

Guardian/Step Parent Name: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____

Guardian/Step Parent Name: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____

Emergency Contact Information:

1. **Name:** _____ **Relationship:** _____ **Phone Number:** _____

   Physical Address: _____
   Street City County ZIP Code

2. **Name:** _____ **Relationship:** _____ **Phone Number:** _____

   Physical Address: _____
   Street City County ZIP Code

3. **Name:** _____ **Relationship:** _____ **Phone Number:** _____

   Physical Address: _____
   Street City County ZIP Code

Physician to be called in an emergency: _____ **Phone:** _____ **Hospital of Choice** _____

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the pace provided below empowers the school authorities to exercise their own judgement to transport the child to a hospital emergency room and allows school physician to complete physical examinations as required by State Law. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent/Legal Guardian Signature: _____ Date: _____

BUS INFORMATION

Check all appropriate boxes

Name of child: _____

___ My child will ride the bus from home and to home every day.

___ My child will need other arrangements. List arrangement here:

EARLY DISMISSAL PROCEDURE:

My child is to go to: _____ on bus # _____.

Relationship to child: _____.

Address: _____ Phone # _____

Circle days this will happen:

Monday Tuesday Wednesday Thursday Friday

Name of older brother/sister neighbor who will ride the same bus and who an act as a "buddy" the first few days of school: _____

ADDITIONAL INFORMATION THAT WILL HELP YOUR CHILD AND HIS/HER TEACHER HAVE A SMOOTH AND PLEASANT BEGINNING TO THE SCHOOL YEAR:

Special Friends: _____

Favorite Activities: _____

Does your child:

_____ do early morning chores or activities
_____ eat breakfast
_____ go to a sitter very early
_____ go slowly in the morning
_____ get along with siblings
_____ tie shoes
_____ bite fingernails

Is your child:

_____ outgoing
_____ shy
_____ fearful in new situations
_____ aggressive
_____ subject to temper tantrums
_____ cry easily
_____ suck thumb

OTHER: _____

_____

Are there other people with whom your child spends much time, i.e. grandparents, babysitter, adult siblings, etc.

List here: _____

_____

Are there any current emotional disruptions to your family, i.e. divorce, death of a family member or special friend, separation, birth of new child, moved to a new home, serious illness of any relative, etc.

_____

Any other pertinent information (or concerns) should be listed on the back.

Home Language Questionnaire

Dear Parent/Guardian:

In order for us to plan an appropriate for your child, we need to determine how well he/she speaks, understands, reads, and writes English. Your assistance in answering these questions is greatly appreciated.

---

1. What language(s) is spoken in the student's home or residence? __English __Other ____

2. What language(s) are spoken most of the time to the student, in the home or residence? __English __Other____

3. What language(s) does the student understand? __English __Other____

4. What language(s) does the student speak? __English __Other____

5. What language(s) does the student read? __English __Other____

6. What language(s) does the student write? __English __Other____

7. In your opinion, how well does the student understand, speak, read, and write English?

	Very Well	Only a little	Not at all
Understands English			
Speaks English			
Reads English			
Writes English			

Signature of Parent/Guardian _____

Date:_____

If the parent or guardian responds to a language other than English for one or more of the questions above, a copy of this form should be forwarded to the Building Principal.

04/07

Cambridge Central School District

Achieving Excellence

Cambridge CSD Health Office
Health History Form

Directions: This is a health history form used by the school health staff. Please fill out completely to help inform us of your child's health history. This form is confidential and kept in a secure location within the health services office.

Section 1: Demographic Information

Student's Name: _____ **Date of Birth:** _____ **Gender:** _____

Place of Birth _____
City County State ZIP Code

Parent/Legal Guardian Information:

Parent/Guardian Name: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Relationship: _____

Physical Address: _____
Street City County ZIP Code

Parent/Guardian Name: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Relationship: _____

Physical Address: _____
Street City County ZIP Code

Physician to be called in an emergency: _____ **Phone:** _____

Hospital of Choice _____

Section 2: Health History:

Has your child ever had or has the following: (please check if **yes** and **explain** in the next section of this form)

___ Asthma
___ ADD/ADHD
___ Allergies (list on the back)
___ Dental Problems
___ Diabetes
___ Eye Problems
___ Ear Problems/Hearing Difficulty
___ Emotional Problems
___ Ever been hospitalized
___ Hear Disease/heart murmur
___ Operations
___ Pneumonia
___ Serious Injury
___ Seizure Disorder
___ Tuberculosis
___ Other: _____

Has your child had any childhood diseases: _____ Chickenpox ____ Other: _____

Section 3: Medication and Medical Services

Does your child take medication on a regular basis? __Yes __ No

If yes – Does your child need to take this medication at school? __Yes __ No

Does your child see a dentist regularly? __Yes __ No

Does your child go for yearly physicals? __Yes __ No

Cambridge Central School District
Achieving Excellence

Cambridge CSD Health Office
Health History Form

Please explain any boxes checked yes under section 2:

_____
_____
_____
_____
_____
_____
_____

May our school nurses share this information with our staff on a need to know basis? ___Yes ___ No

Parent Signature: _____ Date: _____

Please list any medications your child takes on a regular basis:
Does your child need to take any of these medications during the school day? __ Yes __ No

_____
_____
_____
_____
_____
_____
_____

Section 4: Immunizations and Vaccines
New York State Law requires that all children entering school show proof of having received the following immunizations:

4-5 DPT's **3-4 Polio Vaccines** **2 MMR's**
3 Hepatitis B Vaccines **2 Varicella Vaccines**

As of July 1, 2014, all students entering 6th grade must receive a Tetanus, Diphtheria, and Pertussis Booster (Dtap), second Varicella and fourth polio vaccines.

As of September 1, 2016, all students entering 7th grade and 12th grade must have the Meningococcal Vaccine in order to attend school.

Please provide proof of immunizations with an immunization record. This must be provided for enrollment into the Cambridge Central School District.

Cambridge Central School District

Achieving Excellence

Family Information

Student's Name: _____ **Date of Birth:** _____

Gender: _____ **Grade:** _____ **Date of Entry:** _____

Full Name of Siblings	Age	Date of Birth	Grade	Address

Parent/Legal Guardian Information:

Parent/Guardian Name: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Relationship: _____

Physical Address: _____

Street City

County ZIP CODE

Parent/Guardian Name: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Relationship: _____

Physical Address: _____

Street City

County ZIP CODE **Guardian/Step Parent Name:**

_____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Guardian/Step Parent Name:

_____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Cambridge Central School

Health and Dental Examination Requirements

Dear Parents/Guardians, Date:

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd , 5th, 7th , 9th and 11th grade.** The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts Pre-K or K, 1st ,3rd , 5th, 7th , 9th & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a physical exam form and dental certificate for your health care providers is enclosed.
- Communication between private and school health staff is important for safe and effective care at school. Your healthcare provider may not share health information with school health staff without your signed permission. Please talk to your provider about signing their consent form for the school at the time of your child's appointment for the examination.

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Sincerely,

School Nurse: Mary Jane Young		School: Cambridge CSD
Phone #: 518-677-8527 ext1428	Fax: 518-677-2837	Email: Maryjane.young@cambridgecsd.org

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				Not Done
Pure Tone Screening	Right ☐ Pass ☐ Fail	Left ☐ Pass ☐ Fail	Referral ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

HEALTH OFFICE
CAMBRIDGE CENTRAL SCHOOL
24 SOUTH PARK STREET
CAMBRIDGE, N Y 12816
518-677-8527 EXT.1428
FAX: 518-677-2837

Permission to Administer Over-the-Counter (OTC) Medications at School

The following OTC medications are commonly used for the management of minor acute illnesses and injuries. As the parents and health care provider of _____ we give permission for the school nurse to administer these medications in the following doses, at the indicated intervals, when he/she feels they are indicated by the child's condition, without obtaining further permission.

Acetaminophen: 10-15 mg/kg / dose; every 4 hours for pain or fever, by mouth. Maximum 2 doses/day, 5 doses/ month without further permission.

Ibuprofen: 10 mg/kg / dose, by mouth, every 4-6 hours for pain or fever. Maximum 2 doses/day, 5 doses/month without further permission.

Bacitracin ointment: Use as needed on minor cuts or abrasions

Caladryl: Use as directed on minor rashes, insect bites, etc that cause itching.

Hydrocortizone cream: Use as directed for minor skin irritations.

Diphenhydramine: 1-1.5mg/kg/dose, q6hrs for itchiness, allergic reaction, allergy symptoms. Maximum 2 doses/day, 5 doses /month without further permission.

Maalox/Mylanta: 0.5cc/kg.;dose, q 2-4hours for stomach pain or indigestion. Maximum 2 doses/day, 5 doses without further permission.

Robitussin/Guaifenesin Elixir (100mg/5cc): 5cc q 4 hours under age 12, 10cc q 4 hours if 12 years old or above prn cough.

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date

HEALTH OFFICE
CAMBRIDGE CENTRAL SCHOOL
24 SOUTH PARK STREET
CAMBRIDGE, N Y 12816
518-677-8527 ext. 1428

RELEASE TO EXCHANGE CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize you to exchange information regarding _____,
(Student's name)
to include the most recent physical exam and immunization record. Any information you would like restricted list here: _____
_____

This authorization will be in force and effect in preparation for and throughout your child's education at Cambridge Central School or until _____.

This authorization may be revoked in writing at any time.

The information may be exchanged between Cambridge Central School Staff and

Physician's Name _____

_____

Address _____

_____

Telephone Number_____

This release has been authorized by:

Signed _____

Relationship _____

Date _____

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ /____ /____ Grade: ____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school 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 <u>one</u> box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

- ☐ In permanent housing

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

If the student is <u>NOT</u> living in permanent housing, **proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. <u>After</u> the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.**

<u>NOTE TO SCHOOLS/LEAS:</u> If the student is <u>NOT</u> living in permanent housing, please ensure that a Designation Form is completed.

ATENCIÓN ESCUELAS Y DISTRITOS: Ofrezca asistencia a los estudiantes y familias para completar este formulario. No incluya este formulario en el paquete de inscripción sin advertencias apropiadas. Por ejemplo, tendrá que cambiar partes del paquete de inscripción que requieren que se entreguen prueba de inscripción antes de matricular. Estudiantes elegibles según el Acto de McKinney-Vento no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

FORMULARIO DE INSCRIPCIÓN – CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer Fecha de Nacimiento: ____ ____ ____ Grado: _____ ID#: _____
Mes Día año (Jardín de infantes – 12) (opcional)

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.

¿Donde está el estudiante viviendo actualmente? (Por favor marque *una caja*.)

- ☐ En un refugio
- ☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o campiña
- ☐ Otra vivienda temporal (Por favor describa): _____
- ☐ En un hogar permanente

_____ _____
Nombre de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento) Firma de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____
Fecha

Si el estudiante NO vive en un hogar permanente, no se requieren prueba de domicilio u otros documentos normalmente requeridos para inscripción y el estudiante debe ser matriculado inmediatamente. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

ATENCIÓN ESCUELAS Y DISTRITOS: Si el estudiante NO vive en un hogar permanente, favor de asegúrese que una Formulario de Designación sea completado.

Cambridge Central School District
Committee on Special Education
24 South Park Street
Cambridge, NY 12816
518-677-8527 Ext. 1419

Medicaid Consent

2020-2021

Dear Parent/Guardian:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP). Please provide us with your child's **Client Identification Number (CIN)**, which can be found on the left hand side of the card. The CIN number begins with two letters followed by five numbers and ends with a letter. This identification number is needed for Cambridge Central School to bill Medicaid for services.

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____ CIN # _____, have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

schooltool

CAMBRIDGE CENTRAL SCHOOL DISTRICT
PARENT / GUARDIAN ACCESS REQUEST FORM

The Cambridge Central School District can provide access to student information via the SchoolTool link off of our home page. In order to protect the confidentiality of student records, all parents/guardians who want to use this service are required to fill out this form and return it in person to the registrar's office. For security purposes, a photo ID is required when you return the form. If you are unable to bring the form in, you may also choose to have the form notarized and sent to: Parent Portal Registration ATTN: Steve Butz, Cambridge Central School, 24 South Park Street, Cambridge, NY 12816.

Please Print

Parent/Guardian Name: (One per form) _____

(First name, Middle Initial, Last Name)

Parent/Guardian Home Address: _____

Parent Guardian Email Address (*REQUIRED*): _____

ONLY ONE EMAIL ADDRESS PER APPLICATION – Please print email address neatly; this will be your user name

Please list all the children in the household who are/will be enrolled @ Cambridge (Student Name)	Your relationship to student	Reside with student (Yes or No)	School	Grade

I certify that all the above information is true and I have legal authority to access the records of the student(s) listed above.

Signed: _____ Date: _____

Signature and ID must be of that Parent/Guardian shown on the first line *(mm/dd/yy)*

Important: Once the information provided above is verified and processed, you will receive notification via email that your account has been created and instructions on how to get an initial password. When you receive your password, you will be able to access SchoolTool through our website: http://www.cambridgecsd.org, and change your password. Your user name is your email address. Your password should be alphanumeric, containing at least eight characters, two of which must be numeric, i.e. "yankee07", and at least one capital letter.

Office Use Only:	Date: _____	ID Verified	Form & ID Checked By: _____ (First initial, last name)	
District Technology:	Verify Email	Account Created	Date: _____	Initials: _____

Notary Statement (if applicable):

STATE OF: _____ COUNTY OF: _____

On this day personally appeared before me _____, to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed. Witness my hand and official seal hereto affixed this _____ day of _____, _____. Notary Public for the State of _____. Commission expires _____.