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: __________

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.

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:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*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 <u>ONLY</u> **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: ____/____/____ (*Month Day Year*)   Grade: ____ (*preschool-12*)   ID#: ________ (*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 one 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 NOT 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**. After 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.

NOTE TO SCHOOLS/LEAS: If the student is NOT 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　Fecha de Nacimiento: _____ _____ _____　Grado: _____　ID#: _____
☐ Mujer　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 perdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o camping
- ☐ 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: ____________________

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 __________.

TRANSFER NOTIFICATION

This form must be completed for all transfer students and submitted to:

UPON RECEIPT OF PART ONE IN THE SECTION OFFICE, ***THE STUDENT IS ELIGIBLE TO PRACTICE; BUT CANNOT PARTICIPATE IN A CONTEST UNTIL APPROVED BY THE SECTION.***

Please check one: **(The required supporting documentation must be attached.)**

_____ **Waiver Request** *Financial: Requires documented proof of a significant loss of income or a significant increase in expenses. OR Health & Safety: Written documentation from the Superintendent of Schools or HS Principal of the sending school indicating the specific circumstances which necessitated the transfer.*

_____ **School District of Residence (SDR)** (No change of residence. School registration change only.) Student is returning to a school within the district boundaries of his/her residence.

_____ **Divorced/Legally Separated Parents** *A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six months. The legal separation agreement must address custody, child support, spouses support and distribution of assets and be filed with the County Clerk or issued by a Judge.* ***(proof required)***

_____ **Homeless** Student declared homeless by the Superintendent under McKinney-Vento Legislation [NYSED 100.2].

_____ **Other**: Refer to By-Law #30 and state applicable exemption. _______________

_____ **Residency Change** *NYSPHSAA transfer/residency policy states: Refer to By-Law & Eligibility Standards #30. (A residency is changed when one is abandoned and another one established through action and intent. Residency requires one's physical presence as an inhabitant and the intent to remain indefinitely. The mere renting of property within the District does not confer residency.* ***The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA regulations.***

By signing this document I attest that our previous residence has been abandoned by the immediate family and our current residence has been established through action and intent. I attest that the immediate family will be physically residing at our current address as inhabitants and intend to remain indefinitely. I attest that the student has transferred without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

Parent Signature: _______________ Date: _______________

PART ONE

TO BE COMPLETED BY STUDENT'S RECEIVING SCHOOL

Receiving School: _______________ Student's Name: _______________

Date of Transfer: _______ Date of Birth: _______ Grade Level: _______ Date Entered 9th Grade: _______

Student/Family Previous Address: _______________

Student/Family Present Address: _______________

Parent's Names and Current Address(es)

(Parent #1's name & address) _______________

(Parent #2's name & address) _______________

Name of Sending School _______________

Did student participate in athletics at sending school? Yes No

The undersigned herby certify that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

The receiving school's administration is responsible for verification for these and other eligibility requirements.

Superintendent's signature _______________ Date _______

Principal's signature _______________ Date _______

Athletic Director's signature _______________ Date _______

PART TWO TO BE COMPLETED **BY SCHOOL STUDENT PREVIOUSLY ATTENDED**
AND RETURNED TO STUDENT'S PRESENT SCHOOL

Name of Student ____________________________ Date entered 9th grade _______________

Did student repeat any grades? _________ If yes, which ones? ___________________________

Name of School(s) Attended Prior to Transfer ____

Date of entrance to this school ____________ Date of withdrawal from this school _________

Student's address while attending the above school _____________________________________

With whom did student reside at this address (name)? ___________________________________

Relationship of this (these) person(s)? ____________________________________

PART THREE - TRANSFER STUDENT SPORT HISTORY (Please include all sports student participated in.)

	Year	Sport	Level	APP'd (Sel. Class.)		School
7th Grade	______	____________	____	Yes	No	____________________
	______	____________	____	Yes	No	____________________
	______	____________	____	Yes	No	____________________
8th Grade	______	____________	____	Yes	No	____________________
	______	____________	____	Yes	No	____________________
	______	____________	____	Yes	No	____________________
9th Grade	______	____________	____			____________________
	______	____________	____			____________________
	______	____________	____			____________________
10th Grade	______	____________	____			____________________
	______	____________	____			____________________
	______	____________	____			____________________
11th Grade	______	____________	____			____________________
	______	____________	____			____________________
	______	____________	____			____________________
12th Grade	______	____________	____			____________________
	______	____________	____			____________________
	______	____________	____			____________________

The undersigned have no knowledge that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage or to avoid discipline at the sending school.

Superintendent's signature ______________________________ Date __________

Principal's signature ___________________________________ Date __________

Athletic Director's signature ______________________________ Date __________

revised: 1/2016