PERU CENTRAL SCHOOL PO BOX 68 PERU, NY 12972
District Registration Form

Student Information **Today's Date:**

First Name: ____________ Middle Name: ____________ Last Name: ____________

Nickname: ____________ Date of Birth: ____________ Gender: ____________

Ethnicity: (check one) ☐ Native American, ☐ Black (not Hispanic), ☐ Asian, ☐ Hawaiian/Pacific Islander, ☐ Hispanic, ☐ White

Dominant Language: ____________ Birth City / State / Country: ____________

Birth Certificate: ☐ Yes, ☐ No Foreign Exchange Student: ☐ Yes, ☐ No

If applicable: Immigration Status- date of entry to the US: ____________

Lunch Status: (check one) ☐ Free, ☐ Reduced, ☐ Regular

Enrollment Information

Enrollment Date: ____________ Transferred From: ____________ Attended Before: ☐ Yes, ☐ No

Building: ☐ Primary, ☐ Intermediate, ☐ Middle School, ☐ High School Grade Entering: ____________

Attended: (please state names)

Head Start ____________ Nursery School ____________ Pre-School ____________

If applicable: Date Enter 9th Grade: ____________

Remedial and/or Special Education Services: ☐ AIS Reading, ☐ AIS Math, ☐ Speech, ☐ Resource Room, ☐ Self Contained Instruction

Household Information

Physical Address: ____
Number and Street City Zip Code

Mailing Address: ____
(if different) Number and Street City Zip Code

Household Primary Phone Number: ____________ ☐ Listed, ☐ Unlisted

Other Children in the Household:

Name: ____________ DOB: ____________ Grade: ____ Sibling: ☐ Yes, ☐ No

Name: ____________ DOB: ____________ Grade: ____ Sibling: ☐ Yes, ☐ No

Name: ____________ DOB: ____________ Grade: ____ Sibling: ☐ Yes, ☐ No

Name: ____________ DOB: ____________ Grade: ____ Sibling: ☐ Yes, ☐ No

Name: ____________ DOB: ____________ Grade: ____ Sibling: ☐ Yes, ☐ No

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Contacts (First & Second Contacts should be mother or father or guardians)

First Contact Name: ______________________ Relationship to Student: ________________

Check all that apply: ☐ Lives with, ☐ Has Custody, ☐ Gets Mailings, ☐ Household Head, ☐ Alert! **(attach specifics)**

Mailing Address: ____
Number and Street City Zip Code

Phone Number: __________ ☐ Listed, ☐ Unlisted Cell Number: __________

Place of Employment: ______________________ Work Phone Number: __________

Second Contact Name: ______________________ Relationship to Student: ________________

Check all that apply: ☐ Lives with, ☐ Has Custody, ☐ Gets Mailings, ☐ Household Head, ☐ Alert! **(attach specifics)**

Mailing Address: ____
Number and Street City Zip Code

Phone Number: __________ ☐ Listed, ☐ Unlisted Cell Number: __________

Place of Employment: ______________________ Work Phone Number: __________

Emergency Contact 1 Name: __________________ Relationship to Student: ______________

Phone Number: __________ ☐ Listed, ☐ Unlisted Cell Number: __________

Emergency Contact 2 Name: __________________ Relationship to Student: ______________

Phone Number: __________ ☐ Listed, ☐ Unlisted Cell Number: __________

Medical / Legal Information

Disability: ____

Medical Alert: ____

Permission to: ☐ Call Doctor, ☐ Call Ambulance, ☐ Treat

Proof of Immunization: ☐ Yes, ☐ No. Date of Polio Immunization: ______________

Doctors' Name: ______________________________ Doctor's Phone: __________

Doctors Address: ____

Legal Alert: ☐ No, ☐ Yes, **please attach specifics.** Homeless Status: ☐ Yes, ☐ No

Living in: (check all that apply) ☐ Shelter, ☐ With Relatives, ☐ Abandoned Apartment / Building, ☐ Motel/Hotel,
☐ Camping Ground, ☐ Car, ☐ Bus/Train Station, ☐ Other,
☐ Temporarily housed in a shelter awaiting OCFS permanent foster placement

Signature: ______________________________ **Relationship to the student**: ____________

Office Use Only

Assigned to: Grade ____ Teacher ________ Transportation (check one) ☐ Bus, ☐ Walker, ☐ Drop off/Pickup

Date Left District: ____________ Assigned ID Number: ____________ ☐ eSD Auto, ☐ Old or Manual

Peru Central School District
New York State Education Department
Division of Bilingual Education/Bureau of School and Categorical Programs Evaluation
Albany, New York 12234

PARENT/GUARDIAN HOME LANGUAGE QUESTIONNAIRE

School: Peru Central School – Primary Department Class______________________

Relationship of Person Completing Survey: Mother_____ Father_____ Guardian_____

Student Identification Number______________________ Student Name______________________

Directions: Circle the correct response for each of the following questions concerning your child.

1. What language did the child learn when he/she first began to talk? English Other (Specify) ____________
2. What language does the family speak in the home most of the time? English Other (Specify) ____________
3. What language does the mother speak to her child most of the time? English Other (Specify) ____________
4. What language does the father speak to his child most of the time? English Other (Specify) ____________
5. What language does the child speak to his/her mother most of the time? English Other (Specify) ____________
6. What language does the child speak to his/her father most of the time? English Other (Specify) ____________
7. What language does your child speak to his/her brothers and sisters most of the time? English Other (Specify) ____________
8. What language does your child speak to his/her friends most of the time? English Other (Specify) ____________

PERU CENTRAL SCHOOL DISTRICT

K-5 NEW STUDENT HEALTH HISTORY

STUDENT NAME: ____________________________

GRADE: ____ **DATE OF BIRTH:** __________

Please complete all information that pertains to your child (be specific with dates, type of injury, etc.)

Any serious injury or illnesses (such as chicken pox, measles, whooping cough, etc.): ____________________

Musculoskeletal/Orthopedic problems: ____________

Joint pain/swelling: ____________

Fractures/breaks: ____________

Scoliosis: ____________

Heart disease: ____________

Heart murmur: ____________

Rapid heart rate/Palpitations: ____________

Asthma: ________ Meds/Inhalers: ____________

Diabetes: ________ Insulin Pump: ____________

Meds for Diabetes: ____________

ADHD/ADD: ________ Tourette's: ____________

Behavior/attention span issues: ____________

Epilepsy/seizures: ____________

Describe seizures: ____________

Date of last seizure: ____________

Hearing loss/ear infections: ____________

Glasses, contacts, eye problems: ____________

Hospitalizations (list date and reason): ____________

ALLERGIES (describe reaction to any of the following):

Food: ____________

Medications: ____________

Hay fever/environmental: ____________

Bee Stings: ____________

Recommended treatment for the above allergic reaction: ____________

MEDICATIONS (list the name, dosage, and times of any medications your child is currently taking):

1) ____________
2) ____________
3) ____________
4) ____________

Is there any other health information that we should be aware of? ____________

DEVELOPMENTAL HISTORY (GRADES K-2)

Did you have any unusual problems during pregnancy or birth? ____________

Was the infant full term? Yes ___ No ___ Late ___ Early ___ Infants birth weight: ____lbs. ____oz.

Did your child have any illnesses or problems while in the hospital, such as jaundice, blue spells, Seizures? ____________

Please give approximate age your child:
Sat up alone ________, walked ________, said single words _______, said sentences _______, was potty trained ________.

Would you like a conference with the school nurse?
Yes ____ No____ if yes, regarding ____________

____
Parent/ Guardian Signature

____
Date

PERU CENTRAL SCHOOL DISTRICT
HEALTH SERVICES

Notification to Parents Regarding the Required Health Examination

According to State Education Law Article 19, section 903, each pupil entering a public school shall furnish proof of a physical examination done within the last 12 months. If a health certificate is not presented **at the time of registration**, a written notice will be sent in follow up. Then, if the physical is not furnished within 30 days, the school MD/NP will conduct a school exam.

A physical that is conducted by a duly licensed physician, physician assistant, or nurse practitioner, who is authorized to practice in the jurisdiction in which the examination was done (provided that the commissioner has determined that such jurisdiction has standards of licensure and practice comparable to those of New York) may also be accepted. This means a **physical done out of state** is acceptable also. A **physical done out of country** is not acceptable.

Students in grades **Pre-K or K, 2,4,7,10** are required by law to have physicals. A health appraisal or physical should include height, weight, and blood pressure. Vision and hearing screening results should be included if available. A physical is acceptable 12 months prior to the beginning of the school year in which the exam is required.

All children in a **special program** are required to have a physical every three years in order to modify their educational needs.

Any student interested in obtaining a **working card**, ages 11-18, must have a valid physical on file. Appropriate paperwork including social security card, birth certificate and completed application are required.

Finally, children who participate in **interscholastic sports, grades 7 – 12**, must have a valid physical. The physical will be valid for a period of 12 months through the last day of the month in which the physical was done.

If you have any questions, please contact the appropriate Health Services Office.

I prefer to have ______________________________ examined by:

_____School Physical _____ Private Physician

Date: __________________ ______________________________

Signature of Parent or Guardia

NEW YORK STATE IMMUNIZATION REQUIREMENTS
SCHOOL K – 12

Diphtheria Toxoid Containing Vaccine.............3 doses
(DTP, DTaP)
Polio...3 doses
(eIPV,OPV,IPV)
Measles, Mumps, Rubella..............................2 doses of measles containing vaccine and 1 dose each of mumps and rubella (preferably as MMR)
(MMR)
Hepatitis B...3 doses as of the 2005-2006 school year
*****Hep B** –2 doses of adult hepatitis B vaccine (Recombivax) for children 11 – 15 years old is acceptable too.
Varicella.. 1 dose

I understand that is my child transfers from a school district within New York State that I have two weeks from the date of admission or 30 days if transferred from outside New York State, to produce an official record of my child's immunization or in lieu of this either of the following:

a) A written statement subscribed and affirmed as true by a parent or guardian of the child that the parent or guardian is a bona fide member of a specified recognized religious organization whose teachings are contrary to the administration of immunizing agents.
b) New York State licensed physician's certificate stating that the listed immunizations are detrimental to the child's health. This MUST specify which vaccine is detrimental and the length of time for the exemption.

This is to acknowledge that I have been informed of the immunization requirements for admission to schools in New York State as required by the N.Y. S. Public Law, Section 2164. I further understand that, under the law, if the school **DOES NOT** receive the evidence of immunization within the specified period, my child **WILL BE EXCLUDED** from school until such time as the evidence is received.

Finally, I consent to the use of my child's first polio date as part of the New York State School NYSSIS system.

_______________   ______________________________
Date   Signature of Parent or Guardian

SUCCESS BY 6 – <u>Student Information Profile</u> – Peru Primary School

Child's Name________________________________ Date of Birth____________

Name you prefer your child to be called by______________________________________

Person completing form____________________ Relationship to child_____________

Child is living with both parents__________
Mother_____________
Father_____________
Other_____________

Rank in family_____________
Number of children__________
Names/Ages of siblings
____
____
____
____

Please check if your child has attended Daycare______ Head Start_____ Pre-School_______ Nursery School_____

Please check where your child will be picked up: Home_____ Daycare_____

Please check where your child will go after school: Home_____ Daycare_____

Name of Daycare Provider______________________________________

Address of Daycare Provider_____________________________________

Self Help Skills	**Yes**	**No**	**Sometimes**
Can button/unbutton clothing			
Can put on outdoor clothing without help			
Can put on/remove shoes/boots			
Can tie shoe laces			
Is your child toilet trained			
Cares for personal belongings			
Readiness Skills	**Yes**	**No**	**Sometimes**
Plays successfully with puzzles and blocks			
Can hold pencil comfortably			
Can use scissors effectively			
Writes/draws rather than scribbles			
Can write name			
Can color and stay within lines reasonably well			
Recognizes alphabet letters (not just saying ABC's)			
Recognizes numbers 1-10 (not just counting)			
Listens to a story (15 minutes)			
Follows two step directions without you repeating			
Speaks in complete sentences			
Sings/recites familiar songs/rhymes			
Pays attention when spoken to			
Works independently to finish a task			

Prefers to use: right hand_____ left hand_____ both_____

SUCCESS BY 6 – Page 2

Social/Emotional Skills	Yes	No	Sometimes
Participates in group activities			
Takes turns			
Works/plays well with others			
Controls behavior			
Cries easily			
Often has temper tantrums			
Listens/follows adult directions concerning behavior			
Obeys established limits/rules			
Uses words to communicate ideas/feelings			
Is afraid to speak to strangers			
Can be left alone with babysitter without a fuss			
Physical skills	**Yes**	**No**	**Sometimes**
Can your child ride a tricycle/bicycle			
Can your child throw/catch a ball			
Can your child hop, skip, jump			
Can your child use playground equipment correctly			

Health

Name of Family Physician___________________________________

Does your child have allergies (include bee sting)? YES NO
List:

Does your child have health concerns (include ear conditions, headaches, vision problems, operations and serious injuries)? YES NO
Describe:

Does your child take medication? YES NO
List:

Medical History: Please give dates:

Chicken pox________________________
Pneumonia________________________
Rheumatic fever________________________
Whooping cough (RSV)________________________
Diabetes________________________

Epilepsy________________________
Heart disease________________________
Asthma________________________
Scarlet fever________________________
Other conditions:________________________

SUCCESS BY 6 – Page 3

Has your child received any of the following pre-school services? YES NO
If YES, check those that apply.

Speech_______________________ Occupational Therapy____________________

Counseling____________________ Physical Therapy______________________

Early Intervention_______________ Special Education_____________________

Please write any information about your child that may affect school adjustment:

Fears/Special Concerns:

Special lessons/training:

Please describe your discipline method used at home:

Please use this space to ask any questions or concerns you may have:

PERU CENTRAL SCHOOL DISTRICT
Office of Medicaid Reimbursement
Primary School Building
PO Box 68
Peru, New York 12972
Fax 518-643-6045

A. Paul Scott
Superintendent of Schools
Randolph B. Sapp
School Business Administrator

Irene Stephney
Director of Special Education
Data Warehouse CIO
518-643-6043

Jeanette Cumber
Medicaid Liaison
Data Warehouse CIO Assistant
518-643-6107

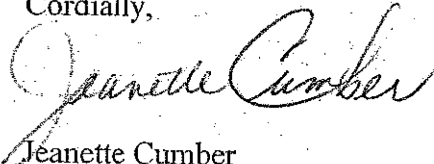
Dear Parent or Guardian:

If a student is Medicaid eligible, has an IEP and receives any special education services at school, the District can request reimbursement from the Medicaid Program for part of the cost of providing these services to the child. There is no cost to the parents for this process. In order to submit for reimbursement on qualifying students, the State of New York requires the school district to have a release form, signed by a parent or guardian, on file each school year.

Peru School has included the release form in all student registration packets. Signing the form does not mean your child receives Medicaid or has an IEP. All forms are forwarded to the Peru School Medicaid office. If the student is identified eligible at the present time or in the future, the district will already have parent consent. This process will maintain confidentiality.

Thank you in advance for taking the time to sign and date the attached form.

Cordially,



Jeanette Cumber
Peru School Medicaid Liaison

PARENTAL CONSENT FOR RELEASE OF EDUCATIONAL INFORMATION FOR MEDICAID FUNDING

TERMS, RIGHTS AND RESPONSIBILITIES

By signing this application, I understand and confirm that:

- I have been fully informed in my native language or other mode of communication that the granting of my consent to share information for the purpose of obtaining Medicaid reimbursement for the services provided per my child's individualized education program (IEP) is voluntary and may be revoked at any time and that if I revoke my consent, it does not negate (undo) an action that occurred after my consent was given and before my consent was revoked.
- If I refuse consent to allow use of Medicaid insurance to pay for special education services, the school district must still provide all required special education services at no cost to me.
- The use of Medicaid insurance for special education services will not decrease the available lifetime coverage, increase premiums or lead to the discontinuation of benefits, result in my family paying for services required for my child outside of school that would otherwise be covered by the Medicaid program or otherwise diminish my family's insured benefits under the Medicaid program
- I will not incur an out-of-pocket expense such as payment of a deductible or co-pay amount.

I, ______________________________________, as parent/guardian of
(Print name of parent or person in parental relationship)

____,
(Print child's name)

give permission to the public agency (school district, municipality_or Medicaid provider) to use Medicaid to pay for IEP services and to such public agency and to each approved private special education school or provider who provides IEP services to my child to disclose information regarding diagnosis and procedure codes for billing Medicaid for services described in my child's IEP and for evaluations in relation to the services; and in the event of an audit, documentation required to support services reimbursed by Medicaid from my child's educational records to local, State and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for covered health-related support services for each service and for each school year in which service is provided as recommended in my child's IEP if my child is or becomes Medicaid-eligible.

I give my consent voluntarily and understand that I may withdraw that consent at any time. I also understand that my child's entitlement to a free and appropriate public education (FAPE) is in no way dependant on my granting consent.

Signature: ______________________________ Date: ____________