

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

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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.)

ALLERGIES (describe reaction to any of the following):

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

Food: _____

Medications: _____

Hay fever/environmental: _____

Bee Stings: _____

Recommended treatment for the above allergic reaction: _____

Musculoskeletal/Orthopedic problems: _____

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

Joint pain/swelling: _____

1) _____

Fractures/breaks: _____

2) _____

Scoliosis: _____

3) _____

Heart disease: _____

4) _____

Heart murmur: _____

Rapid heart rate/Palpitations: _____

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

Asthma: _____ Meds/Inhalers: _____

DEVELOPMENTAL HISTORY (GRADES K-2)

Diabetes: _____ Insulin Pump: _____

Meds for Diabetes: _____

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

Was the infant full term? Yes ___ No ___ Late ___

Early ___ Infants birth weight: ___ lbs. ___ oz.

ADHD/ADD: _____ Tourette's: _____

Behavior/attention span issues: _____

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

Epilepsy/seizures: _____

Describe seizures: _____

Please give approximate age your child:

Sat up alone _____, walked _____, said single words _____, said sentences _____, was potty trained _____.

Date of last seizure: _____

Hearing loss/ear infections: _____

Glasses, contacts, eye problems: _____

Would you like a conference with the school nurse? Yes ___ No ___ if yes, regarding _____

Hospitalizations (list date and reason): _____

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
(MMR) vaccine and 1 dose each of mumps
and rubella (preferably as 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 if 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

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: _____