CANASTOTA
Central School District

Striving for Excellence

WELCOME TO CANASTOTA CENTRAL SCHOOL DISTRICT

Enclosed you will find the registration packet for your child. The processing time for this packet is approximately two school days from the day it is submitted. This ensures that your child's transportation, food service accounts and classroom needs will be properly addressed.

When you have completed the attached forms and have all the listed items below you will then need to schedule an appointment with the District Registrar, Amanda Snyder at 315-697-6326.

When returning this packet, please attach the following items:

Child's Birth Certificate
Child's Immunization Records
Adult's proof of residence in the Canastota School District
ex: lease agreement with name and address, utility bill, etc.
(post office box cannot be used as a proper resident address)
Any school records from previous school(s) ex: last report card
Custodial papers (if applicable)

All above items must be received by the registrar before a student can be registered into the district. Students may not start school unless all forms have been received.

If you have any questions please do not hesitate to call Mrs. Amanda Snyder the Central Registrar at 315-697-6326. If there is no answer, please leave a message and your call will be returned promptly.

Welcome to Canastota.

Form Updated: 22-Aug-23

Canastota Central School District
STUDENT REGISTRATION FORM

Student Information:

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Sex: _____ Grade _____ Student ID # _____ Date Registered _____

Residential Address (include Apt. #) Mailing Address (if different)

_____ _____

_____ _____

Ethnicity: **(Choose one)**
Is student Hispanic, Latino or of Spanish origin ? ☐ Yes Hispanic ☐ No Non-Hispanic
(means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)

Race: **(Choose one or more, regardless of Ethnicity)**
☐ American Indian or Alaska Native (origins to original peoples of North America and who maintains cultural identification)
☐ Asian (origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent)
☐ Native Hawaiian or Other Pacific Islander (origins of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)
☐ Black (origins in any of the black racial groups of Africa)
☐ White (origins in any of the original peoples of Europe, North Africa, or the Middle East)

Parental/Guardian Information: **(relationship: natural parent, step parent, guardian, foster parent, other)**

Male Guardian: _____ Employer: _____ Work Phone: _____

Relationship: _____ Email: _____ Cell Phone: _____

Residential Address: Mailing Address: Home Phone: _____

_____ _____

_____ _____

Female Guardian: _____ Employer: _____ Work Phone: _____

Relationship: _____ Email: _____ Cell Phone: _____

Residential Address: Mailing Address: Home Phone: _____

_____ _____

_____ _____

Any special information regarding CUSTODY that office staff needs to be aware of (example: Order of Protection, notifications (report cards/mailings) need to be sent to a 2nd parent- please provide address

2nd Parent Name: _____ Address: _____

_____

Custodial Information: _____

Emergency Contacts

Emergency Contact: _____ Relationship: _____ Phone #: _____

Child Care Provider: _____ Address: _____ Phone #: _____

Siblings at Same Address (who are school age or younger)

Full Name	Date of Birth	Grade (if in School)	School Attending

COMPLETE THIS BOX ONLY IF 1: IT REFLECTS YOUR CHILD'S CURRENT LIVING SITUATION OR 2: YOUR LIVING SITUATION - IF YOU ARE A YOUTH NOT LIVING WITH A PARENT OR GUARDIAN

Check one box if you are living:

☐ in a shelter ☐ with relatives or others due to lack in housing ☐ at a train/bus station, park or in car
☐ in a motel/hotel, camping ground or other similar situation due to lack of alternative, adequate housing
☐ in an abandoned apartment/building ☐ temporarily housed in a shelter awaiting permanent foster care

Language(s) spoken at home other than English

Parent _____ Child _____ Need Interpreter _____

School History

Has student previously attended Canastota Central Schools? Yes ____ No ____ When _____

Pre-School Attended: _____ When: _____

Last School Attended: Name of School : _____ Phone #: _____

When: 20__ to 20 __ Grade: ____ Address of School: _____

Were AIS/Title I Services Provided? Math: Yes _____ No ____ Reading: Yes: _____ No: ____ Other : _____

Does your Child have an IEP? Yes: _____ No: _____ 504 Accommodation Plan? Yes: _____ No: _____

If Child has IEP , what program/services ? Special Class Type ____ Resource ____ Adaptive Physical Ed ____

Speech Therapy ____ Occupational Therapy ____ Physical Therapy ___ Other _____

Involvement of Outside Agencies (Social Services, Probation, Counseling, Etc.)

_____

****

Registering Parent/Guardian's Name _____ Parent/Guardian Identification _____

Registering Parent/Guardian's Signature _____ Date of Registration _____

CANASTOTA CENTRAL SCHOOLS
PRE-REGISTRATION RESIDENCY/CUSTODIAL FORM
(updated 22-Aug-23)

Student Name: _____ Date of Registration: _____

LEGAL CUSTODY
List **ALL** who have legal custody of the child. Please provide documentation if separated or divorced.

_____ _____
Name Relationship

_____ _____
Name Relationship

PHYSICAL CUSTODY
Canastota Household Members: List who has **physical custody** of student. (Address of student's primary residency)

_____ _____
Father Parent/Guardian Name Mother Parent/Guardian Name

_____ _____
Address of Above Address of Above

_____ _____
City/State/Zip City/State/Zip

( ) Natural Father _____ ( ) Natural Mother _____
( ) Stepfather _____ ( ) Stepmother _____
( ) Legal Guardian _____ ( ) Legal Guardian _____
( ) Other _____ ( ) Other _____

Documentation Given – All Forms Attached - Filled in by Office Staff Only
____ Birth Certificate
____ **Shot Record** (in health perm – not attached)
____ Proof of Residency - Documentation Provided/Date _____
____ Custodial - Type and Date of Form _____
(Custodial Forms below must be completed and approved before registration)

Date Received		**Approved/Disapproved**
_____	Affidavit of Emancipation	_____
_____	Residency Application	_____
_____	Custodial Affidavit	_____
_____	Parent Affidavit	_____
_____	Other	_____

HOUSING QUESTIONNAIRE

Name of LEA: Shawn Bissetta, Superintendent of Canastota Central School District

Name of School: Canastota Central School District

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 **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

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

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

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

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

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:			
First	*Middle*	*Last*	
DATE OF BIRTH:			GENDER:
Month	*Day*	*Year*	❑ Male ❑ Female
PARENT/PERSON IN PARENTAL RELATION INFO:			
Last Name	*First Name*		*Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ ***If yes**, please explain:_____

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

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ **No** ☐ **Yes*** **Please complete 10b below*

10b. *If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ **No** ☐ **Yes – Type of services received:**_____

Age at which services received *(Please check all that apply):*
☐ **Birth to 3 years (Early Intervention)** ☐ **3 to 5 years (Special Education)** ☐ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ☐ **No** ☐ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ☐ **Mother** ☐ **Father** ☐ **Other:**_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

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

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

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

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

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

Date: _____

School Name: _____ School Phone: _____

Attn: _____ School Fax: _____

Address: _____ Special Ed. Ph: _____

CSZ: _____ Special Ed Fax: _____

To whom it may concern,

According to the Final Regulations-Family Educational Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It states that school officials, including teachers within an educational institution and officials of other schools in school systems in which the student may intend to enroll, may receive a student's record without a written consent for such release.

Registering Parent/Guardian: _____
(Signature)

We would appreciate the following information on:

Name: _____ **Birth date:** _____ **Grade:** _____

Student will be attending the following school – Please send all information to checked school

☐ Canastota High School (Grades 7-12)
Attn: Guidance Office (315-697-6326/Phone)
101 Roberts St. (315-697-6314/Fax)
Canastota, NY 13032

☐ South Side Elementary (Grades 2/3)
Attn: Principal (315-697-6372/Phone)
200 High Street (315-697-6364/Fax)
Canastota, NY 13032

☐ Robert Street Elementary (Grades 4-6)
Attn: Principal (315-697-2029/Phone)
120 Roberts St. (315-697-6343/Fax)
Canastota, NY 13032

☐ Peterboro Street Elementary (Grades PK-1)
Attn: Principal (315-697-2027/Phone
211 N. Peterboro St. (315-697-6355/Fax)
Canastota, NY 13032

☐ District Registration: Amanda Snyder
(☐ GED or ☐ BOCES program)
Same as Guidance – High School

☐ PPS Office (Special Education)
SEND ALL Special Ed Records to this office
101 Roberts Street (315-697-8805/Phone
Canastota, NY 13032 (315-697-6336/Fax)

Please send records including

___ Grades Earned this year/withdrawal grades
___ Report Cards
___ Transcript
___ Test Scores/Competency Results
___ Lab Reports for Regents Science (HS only)

___ Most Current IEP/504 Plan
___ Most Recent Psychological Test
___ Most Recent OT/PT/Speech Evaluation
___ Last Special Education Progress Report
___ Most Recent Social History
___ AIS Records

___ Attendance Records
___ Discipline Summary
___ Health Records: Including Immunization/Latest Physical

Canastota Central School District

Request for NEW Student Transportation

Student Name: _____

PSES SSES RSES High School BOCES Program GED Grade: _____ (AM/PM if Pre-K)

Health Issues/Accommodation Driver should be aware of: _____

Home Address - Location #1

Parent/Guardian(s): _____ Relationship: _____

House #: _____ Apt. #: _____ Home Phone: _____

Street/Road Name: _____ Cell Phone: (Male) _____ (Female) _____

City/Town: _____ Work Phone: (Male) _____ (Female) _____

Location #2 – Alternate Address

Parent/Guardian(s) : _____ Relationship: _____

House #: _____ Apt. #: _____ Home Phone: _____

Street/Road Name: _____ Cell Phone: (Male) _____ (Female) _____

City/Town: _____ Work Phone: (Male) _____ (Female) _____

The Transportation Department will only accommodate pick up and drop off schedules that are consistent. An example of consistent schedule would be:

Pick up and drop off will be at home Monday, Tuesday and Friday
Wednesday and Thursday pick up and drop off will be at the sitters

The Transportation Department cannot SAFELY accommodate multiple pick up and drop off points throughout the week.

Pick-up & Drop-off Request

Please indicate at which location *(use H or #1 from above)* the student is to be picked up or dropped off at in the appropriate box for the day of the week.

	Monday	Tuesday	Wednesday	Thursday	Friday
Pick-up Location (AM)					
Drop-off Location (PM)					

Is student a walker: ☐ Yes ☐ No Effective Date: _____

Parent/Guardian Signature: _____ Date: _____

For office use only:

Date Received: _____ Signature: _____

Date Completed: _____ Signature: _____

CANASTOTA CENTRAL SCHOOL DISTRICT
SchoolTool Parent/Guardian Access Request Form

The Canastota Central School District is pleased to provide parents and guardians with access to student information records via the SchoolTool Parent Portal. In order to protect the confidentiality of student records, all parents/guardians who would like access are required to complete this form and return it **in person** to a Main Office in any of our schools. For security purposes, a photo ID is required when you return this form. Please note that the District's use of SchoolTool is supported by technical assistance from the Mohawk Regional Information Center (MORIC), Mindex, Inc., and other possible consultants. Employees of these entities are instructed to keep confidential any personally identifiable information, including educational records, they may view during the performance of their duties.

Parents and Guardians are required to adhere to the following SchoolTool Parent Portal guidelines:

- Parents/Guardians will access data solely in regard to their child(ren).
- Parents/Guardians will not access any account assigned to another user.
- Parents/Guardians will not intentionally transfer any virus or malicious computer code to SchoolTool.
- Please do not share your password with anyone, including your children.
- Please do not allow your computer to "remember" your Parent Portal password.

Parent/Guardian Name (*one name per form*): _____

Parent/Guardian Home Address: _____

Parent/Guardian Email Address (**REQUIRED**): _____

Only one email per application. Your email address will be your username.

Please list all children who are/will be enrolled at Canastota (student name)	Your relationship to student	Reside with student? (Yes or No)	Student Date of Birth

You only need to fill this out once. New children will automatically be added after they are registered.

I have read the SchoolTool Parent Access Form and agree to abide by and support the guidelines. I understand that the SchoolTool database is maintained by Canastota CSD with support from the Mohawk Regional Information Center of the Madison-Oneida BOCES. I certify that all of the above information is true and I have legal authority to access the records of the student(s) listed above. I understand that the District maintains ownership of all information contained within SchoolTool and reserves the right to restrict or revoke access to anyone in violation of these guidelines.

Signed: _____ **Date:** _____

Important: Once the information on this form is received, verified, and processed, you will receive notification via email that your SchoolTool Parent Portal account has been created. The email will also contain instructions to complete the registration process.

Office Use Only: Date: _____ ☐ ID Verified Form & ID Checked by: _____

Office Use Only: ☐ Account Created Date: _____ By: _____

Call Order Form

Please use this section to indicate the order in which you would like to receive calls from school. Phone calls from school include calls from teachers, administrators and staff, as well as automated phone calls for attendance, snow days and other general information or emergencies. **Names and phone numbers listed below must be Authorized Contacts 18 years or older. Please list *up to* 4 numbers.**

	Contact Name	**Contact Number (list one # per box)**
First Number Called		
Second Number Called		
Third Number Called		
Fourth Number Called		

Date _____ Signature of Parent/Guardian _____ Relationship to Child _____

Student Health Inventory

___ PSES (PK-1) ___ SSES (2-3) ___ RSES (4-6) ___ CHS (7-12) School Year: 20____-20 ____

The following is a brief heath form that must be returned to your child's school nurse annually. This information will be reviewed by the school nurse and used to meet you child's health needs at school.

Student's Name: _____ Date of Birth: _____

Gender assigned at birth: Male _____ Female _____ Grade: _____ Teacher: _____

Please list student's current medications: _____

The School Nurse may treat my child with the following first aid medications consistent with their label usage: Triple antibiotic ointment, 1% hydrocortisone cream, caladryl, aloe gel, bee sting wipes, antiseptic wound cleaner/towelettes ___ Yes ___ No Signature _____

Please check below any conditions that applies to your child:

___ My child has no health conditions

___ ADD/ADHD (see below)	___ Diabetes (see below)	___ Migraine Headaches	___ Sickle Cell Anemia
___ Allergies (see below)	___ Down Syndrome	___ Neuromuscular Disease	___ Tympanostomy (PE) Tubes
___ Asthma (see below)	___ Epilepsy/Seizures (see below)	___ Muscular Dystrophy	___ Ulcers/ Gastric Reflux
___ Autism	___ Heart Problems (see below)	___ Orthopedic Disability	___ Vision Concern
___ Cerebral Palsy	___ Hemophilia/Bleeding disorder	___ Psychiatric Condition	___ Glasses
___ Concussion, Date: ___	___ Hospitalization (see below)	___ Renal/Kidney Disease	___ Contact lenses
___ Cystic Fibrosis	___ Leukemia/Cancer	___ Recent Surgery	

For conditions listed above, please provide additional information below:

ADD/ADHD	Does your child require medication (for this condition) to be taken at school: ___ Yes* ___ No
Allergies	Does your child have any of the following allergies: ___ Bees ___ Food ___ Medication ___ Seasonal ___ Other If yes, please list specific allergen and reaction (hives, swelling, vomiting, difficulty breathing, etc.): _____ Date of last allergic reaction: _____ Is emergency medication required at school? ___ Yes* ___ No
Asthma	Date of last asthma episode: _____ Is medication or treatment required at school? ___Yes* ___ No List medications used to treat asthma episodes: _____
Diabetes	Which type? ___ Type 1 ___Type 2 How is it controlled? ___ Oral medication ___ Insulin ___ Diet Is medication treatment required at school? ___ Yes* ___ No
Seizures	Date of last seizure: _____ Type of seizures: _____ Is student aware of impending seizure? ___ Yes ___ No Is rescue medication required at school? ___ Yes* ___ No
Heart Problems	Check type: ___ Functional heart murmur ___ Heart Valve condition ___ Other (please list) _____ Is exercise limited? ___ Yes* ___ No
Neuromuscular Disease/ Orthopedic Disability	Name of condition: _____ School concerns: _____
Other Health Concerns/Disability	Name of condition: _____ School concerns: _____
	***Indicates that additional physician documentation may be required. See School Nurse for information and forms.**

I understand that in a health or safety emergency involving my child school officials may share confidential health information with appropriate and necessary health, safety or welfare officials.

Signature of parent of guardian: _____ Date: _____