BOLTON CENTRAL SCHOOL DISTRICT
26 Horicon Ave.
Bolton Landing, NY 12814

New Student Registration
Residency Verification Form

Student Name(s) ____________________ ______________________
____________________ ______________________
____________________ ______________________

Parent Name(s) ______________________________
____

Address Primary Residence (Domicile)
____
____
____

Do you own your home: Rent: ☐ Other: ☐

If owner, please provide evidence (telephone, utility, tax bill)

If rent/lease, please provide a copy of rental/lease agreement

If other, please provide proof of residency

Please provide: ____________________________
____
____
____

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 (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, please ensure that a Designation Form is completed.

BOLTON CENTRAL SCHOOL

Child/Children's Name(s)____

Transportation Information

Physical (911) Address ____

Neighbor's name or other identifying features of your residence.________________________
____

Will your child be riding the bus to and from school on a daily basis unless otherwise notified?
Yes____ No____

Will they be picked up at home ____ Child Care Provider ____
Child Care Provider's Address____

Will they be dropped off at home____ Child Care Provider ____
Child Care Provider's Address (if different than a.m.)________________________
____

Parents and Guardians:

Please be aware that under NYS Education Law Section 4402, Chapter 434 of your rights regarding the referral and evaluation of your child for the purposes of special education services or programs.

You can access NYSED's: ***A Parent's Guide to Special Education*** via our school website under our district link. If you do not have access to our website you may call 518-644-2400 to request a copy of this guide be sent to you.

Please return bottom sign off to Bolton CSD with all registration materials.

I understand my rights pertaining to Special Education.

Child(ren)'s Name ______________________________

Parent/Guardian Signature ________________________

Date __________

BOLTON
CENTRAL SCHOOL

26 HORICON AVENUE
BOLTON LANDING, N.Y. 12814

AlertNow Telephone Contact Information

Student Name(s): ____________________
____
____
____

The AlertNow Calling System will call up to **three telephone numbers** in case of a school closing, emergency situation, or a general announcement. Please list the name of the person and number you would want the system to call to notify you in these circumstances. Please do not list numbers that are not a direct line to you or your emergency contact.

Name	Number	(Circle Type of Phone)
1.____________________	____________	Home Work Cell
2.____________________	____________	Home Work Cell
3.____________________	____________	Home Work Cell

Photo Release

Many times during the school year photographs are taken of our students. There are occasions when we would like to use these photographs in the newspaper or other publications. Please check and sign below stating whether you do or do not give us permission to use your student(s)' photo.

I DO give permission _____

I DO NOT give permission_______

Parent/Guardian Signature______________________________Date___________

PHONE 518-644.2400 FAX 518-644.2124 WEB SITE www.boltoncsd.org

PRE-K HEALTH HISTORY

Child's Name ______________________ **Date of Birth** ________________

Your Name ______________________ **Relationship to Child** ________________

Pregnancy/Birth History	Yes	No	**Explain "Yes" Answers**
1. Did mother have any health problems during this pregnancy or delivery?			
2. Was child born more than 3 weeks early or late			
3. What was child's birth weight?	XX	XX	______ lbs. ______ oz.
4. Was anything wrong with child in the nursery?			
5. Did child or mother stay in hospital for medical reasons longer than usual?			
Hospitalizations and Illnesses	**Yes**	**No**	**Explain "Yes" Answers**
6. A. Has child ever been hospitalized? B. Has child ever been operated on?			
7. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?			
8. Has child ever had a serious illness?			
Health Problems	**Yes**	**No**	**Explain "Yes" Answers**
9. Does child have frequent sore throat cough urinary infections or trouble urinating stomach pain, vomiting, diarrhea			
10. Does child have difficulty seeing (squint, cross eyes, look closely at books)?			If "yes" Was last checkup more than one year ago?
11. Is child wearing (or supposed to wear) glasses?			
12. Does child have problems with ears/ hearing (pain, earaches, discharge, rubbing one ear)?			
13. Has child ever had a convulsion or seizure? Is child taking medicine for seizures?			If "yes" ask: When did it last happen? ____________ What medicine?
14. Is child taking any other medicine now? (Special consent form must be signed to administer any medication.)			What medicine? ____________ If "yes" will it be given while child is at school? ____________ How often?
15. Is child now being treated by a physician or a dentist? Physician's Name: ______________________ Phone: ____________ Dentist's Name: ______________________ Phone: ____________			

16. Has child had: (please check)

Chicken Pox German Measles Measles Mumps

Eczema Scarlet Fever Whopping Cough

17. Has child had: (please check)

Bleeding Tendencies; Epilepsy; Liver Disease

Heart/ Blood Vessel Disease; Sickle Cell Disease;

Rheumatic Fever, Asthma; Diabetes

If "yes" please explain.

18. Does child have any allergy problems (rash, itching, swelling, difficulty breathing, coughing, sneezing)?

When eating any foods?

When taking any medication?

When near animals, furs, insects, dust, etc.?

If "yes" please explain.

What foods? ____________

What medicine? ____________

What things? ____________

How does child react?

____

19. Does your child take a nap? No Yes. Describe when and how long

20. Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late)? No Yes.

If "yes" describe arrangements (own room, own bed, and so forth.)

21. How does your child tell you he/she has to go to the toilet?

22. Does your child need help in going to the toilet during the day or night, or does your child wet his/her pants? No Yes. If "yes" please describe.

23. Children learn to do things at different ages. We need to know what each child already can do or is learning to do easily and where they might be slow or need help.

	Age Completed:		Age Completed:
a. Sit up Without Help	____________	d. Talk	____________
b. Crawl	____________	e. Feed & Dress Self	____________
c. Walk	____________	f. Learn to Use Toilet	____________

24. Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? No Yes.

If "yes" please describe:

BOLTON CENTRAL SCHOOL
HEALTH HISTORY INFORMATION

Student's Name________________________________DOB______________Sex__________Age__________

Mother's Name________________________________Father's Name________________________________

Lives with: _______Mother & Father_______Mother _______Father _______Mother/Stepfather

_______Father/Stepmother _______Foster Parents/Guardians

Student's Physician____Phone________________________________

OTHER HEALTH DATA										
Check yes and add year if your child has had any of these:										
Allergies to:	**Yes**	**Yr**	**History of**	**Yes**	**Yr**	**Any Chronic Conditions**	**Yes**	**Yr**	**List any Surgery**	
Bee Sting			Asthma			Diabetes				
Environmental			Pneumonia/Bronchitis			Epilepsy				
Foods – Please list:			Hearing problems/ear infections			Heart Disease				
			Vison problems/glasses			ADHD				
Medications – Please list			Chicken Pox			Tuberculosis				

Does this student take daily prescription medication; (antibiotics, anti-convulsants, ADHD medications, allergy medication or medication for food or drug reaction? If so, please list:________________________________

____

Please advise school nurse if medication is to be taken at School.

Is there any physical limitations preventing this student from participating in physical education activities?______________

____

Is there any special health conditions the school should be aware of, if so please describe:________________________________

____

____

Bolton Central School District
Social History

CONFIDENTIAL

Date Completed: ____________________

Student: ____________________ DOB: ____________ Sex: ________

Home Address: ______________________________ Age: ________

Home Phone: ____________

A. CURRENT PARENT/GUARDIAN DATA

Father: ____________________ Mother: ____________________

Address: ____________________ Address: ____________________

DOB: ________ Home Phone: ________ DOB: ________ Home Phone: ________

Occupation: ____________________ Occupation: ____________________

Place of Employment: ____________ Place of Employment: ____________

Work Phone: ______ Work Hours: ______ Work Phone: ______ Work Hours: ______

Emergency Contact: Name: ____________________ Phone: ____________

B. SIGNIFICANT FAMILY MEMBERS

Name	DOB	Relationship	Highest Grade Completed	In Home (Please Check One)	Out of Home

7.

C. Health/Development of Child

1. Health complications prior, during and/or after birth:

2. Developmental milestones:

Age:		Comments:
_______	Sat	____________________
_______	Walked	____________________
_______	Talked	____________________
_______	Toilet Trained	____________________

3. Is your child able to:

snap	yes/no
zip	yes/no
button	yes/no
tie shoes	yes/no

4. Does your child receive regular preventative care?

   Doctor?

5. Please describe any that apply, indicate date(s), and attending physician's name:

   Frequent Headaches:

   Serious Fevers:

   Seizures:

   Diseases:

   Allergies:

   Serious Injuries:

   Hospitalizations:

   Hearing/Ear Infections, tubes:

   Vision:

   Other: ________________________________

6. Prescribed medications (name of medication, dates begun and ended):

D. CHILD CHARACTERISTICS

1. How would you describe your child's "personality"?

   Please check the terms that most closely describe your child:

   ____ Self Confident ____ Independent ____ Fearful ____ Disobedient ____ Happy

   ____ Easy Going ____ Anxious ____ Worried ____ Depressed ____ Active

   ____ Responsible ____ Changeable ____ Passive ____ Clinging ____ Unkind

   ____ Withdrawn ____ Outgoing ____ Cruel ____ Considerate ____ Shy

   ____ Thoughtless ____ Unfriendly ____ Friendly ____ Aggressive

   ____ Cooperative ____ Forgetful ____ Hostile ____ Defiant

   ____ Other ____

2. What is your child's relationship with significant family members?

3. Is there any language, cultural or religious factors that influence your child?

4. Does your child seek friendship of peers?

5. Is your child sought by peers for friendship?

6. What are your child's favorite activities?

7. a. What kind of disciplinary techniques do you use with your child?

   b. Are they effective?

8. How does your child respond to authority?

9. Does your child exhibit any behaviors/traits which are of concern to you? Have you noticed any changes in his/her personality? (e.g. temper tantrums, phobias, bed wetting, sleep or eating problems)

10. What are your child's strengths and special needs? ______________________________

____

E. SIGNIFICANT FAMILY EVENTS

1. Describe major changes within the family (e.g. separation, divorce, death of significant others, incarceration, suicide, employment, adoption, recent births, foster care, physical or sexual abuse)

   How has your child dealt with these changes?

2. Describe major family health issues and their effects on your child (e.g. lengthy injuries, serious illness, mental illness, substance abuse, etc.)

F. IS THERE ANY OTHER INFORMATION THAT WE SHOULD KNOW? IF SO, PLEASE USE THE SPACE BELOW.

Person Providing Data: ______________________ Relationship to Child: __________