Wellsville Central School District

Welcome to the Wellsville Central School District. A meeting will be scheduled to go through the registration packet together, below is a list of items we will need and some questions that will help us assist you in getting your student registered.

☐ Yes ☐ No Does your student have an Individual Education Program (IEP)?

☐ Yes ☐ No Does your student have a 504 plan?

☐ Photo ID of Parent/Guardian, driver's license or passport

☐ Student's birth certificate or passport, immunization record, copy of latest physical

☐ Proof of Residency

One of the documents listed below with your name and a Wellsville School District address on it:

- ☐ - Utility Bill (Water, Gas or Electric)
- ☐ - Payroll Document
- ☐ - Vehicle Insurance Card
- ☐ - Vehicle Registration
- ☐ - Medical Insurance Card
- ☐ - Homeowners Insurance Statement

If you are NOT a resident of the School District and you do not have any of the documents listed above, you must provide one of the three following documents:

- ☐ - Lease
- ☐ - Purchase Offer
- ☐ - Letter on your builder's letterhead

☐ Custody papers and/or Order of Protection (if applicable)

☐ Department of Social Services Foster Placement form (if applicable)

☐ Completed registration packet, one per student

There is an electronic version available on our website, www.wellsvilleschools.org

Registration materials must be brought to the District Office in person on:

______________________________ at ____________________.

We look forward to meeting with you and having the opportunity to prepare your child to be successful, contributing members of their community through excellence in education.

You may bring your completed registration packets with you to your meeting, e-mail completed registration packets, without signatures, to Registration@wlsv.org, or fax to 585-596-2177. If you have any questions please contact the District Office at 585-596-2173.

Wellsville Central School District

Registration Packet

SCHOOL: ______________________ TODAY'S DATE: ______________

GRADE: ______________________ ENTRANCE DATE: ______________
Official Use Only Official Use Only

STUDENT INFORMATION

Name: ____
LAST, FIRST MIDDLE (FULL)

Name to be called at school, if different? ______________________

Birth Date: ______________ Gender: ☐ M ☐ F Current or Last Grade: ________

Student's Residence: ____
NUMBER STREET APT. # or PO BOX

____
TOWN STATE ZIP CODE

Telephone: ______________________ ______________________
PRIMARY SECONDARY

If you are not yet in the Wellsville District, what is the date you will be moving in? ______________

Current address: ______________________

Current Phone: ______________________

Does the child reside with both parents? ☐ Yes ☐ No *(If NO, answer questions below)*

Who does the child reside with? ______________________

Who has primary placement? ______________________
(DOCUMENTATION IS REQUIRED)

Other pertinent informaiton: ______________________

Has the child ever attended Wellsville Central Schools before? ☐ Yes ☐ No

If yes, what grade(s)? ______________________

Date student first attended New York State Schools: ______________________

What language is primarily spoken at home? ______________________

Was your child born in the United States: ☐ Yes ☐ No *(If NO, answer questions below)*

What country was your child born in? ______________________

Date of entry into the United States? ______________________

Date your child first started school in the United States? ______________________

PARENT/GUARDIAN INFORMATION

Adult #1:

LAST FIRST MIDDLE (FULL)

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other

ADDRESS CITY STATE ZIP CODE

PRIMARY TELEPHONE SECONDARY TELEPHONE

EMAIL ADDRESS (**REQUIRED FOR PARENT PORTAL)

EMPLOYER OCCUPATION

Relationship to this child: ☐ Parent ☐ Stepparent ☐ Guardian ☐ Foster ☐ Other

Adult #2:

LAST FIRST MIDDLE (FULL)

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other

ADDRESS CITY STATE ZIP CODE

PRIMARY TELEPHONE SECONDARY TELEPHONE

EMAIL ADDRESS

EMPLOYER OCCUPATION

Relationship to this child: ☐ Parent ☐ Stepparent ☐ Guardian ☐ Foster ☐ Other

NON-CUSTODIAL PARENT/GUARDIAN, IF APPLICALBE

Name:

LAST FIRST MIDDLE (FULL)

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other

ADDRESS CITY STATE ZIP CODE

PRIMARY TELEPHONE SECONDARY TELEPHONE

EMAIL ADDRESS

EMPLOYER OCCUPATION

Relationship to this child: ☐ Parent ☐ Stepparent ☐ Guardian ☐ Foster ☐ Other

SIBLING INFORMATION (Please list children under the age of 21 who reside in household)

Name (Last, First MI)	Birth Date	Gender	Grade	School to Attend

RACIAL/ETHNIC GROUP

YOU MUST ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND.

1. Check the box that best describes your child. Check **ONLY ONE** box.
   Is the student Hispanic, Latino, or of Spanish origin? (Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)

   ☐ **YES,** Hispanic ☐ **NO,** not Hispanic

2. **Select one or more races from the following five racial groups.** (Check all groups that apply to your child; check at least ONE box):

   ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

   ☐ **BLACK OR AFRICAN AMERICAN**: A person having origins in any of the Black racial groups of Africa

   ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ **AMERICAN INDIAN OR ALASKA NATIVE** (including Hispanic as described above): A PerSon having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or a community attachment.

   ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia,

EMERGENCY CONTACT INFORMATION (IF PARENTS CANNOT BE REACHED)

Name/Address: ____________________

Telephone: ____________________ Relationship to Student: ____________________

Name/Address: ____________________

Telephone: ____________________ Relationship to Student: ____________________

REQUEST FOR RECORDS

Student's Name: ____________________

Name of Last School Attended: ____________________

Address of Last School Attended: ____________________

Telephone Number: ____________________ Fax Number: ____________________

I give my permission for confidential reports, school and health records to be released for this child.

____

Print (Parent/Guardian) Signature Date

McKINNEY-VENTO ACT

If you reside with relatives or others due to loss of housing, economic hardship or similar reason or in a shelter, car, park, public space, abandoned building, camp-site, motel, substandard housing, bus or train station or similar setting; if you are abandoned in a hospital or are awaiting foster care placement; or have a primary night time residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation or in any other temporary living situation because you cannot afford housing, you or your child may be eligible for services. Please contact our homeless liaison by calling: (585) 596-2173.

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.

HOUSING QUESTIONNAIRE

*Please check **only one** box, print name and sign.*

Where is the student currently living?

- ☐ In permanent housing (homeowner, lease, rent)
- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (someimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train or campsite
- ☐ Other temporary living situation (Please describe): ______________________

____

Print (Parent/Guardian) Signature Date

DISCLOSURE OF HEALTH INFORMATION

Student's Name: ______________________________
LAST, FIRST, MIDDLE (FULL)

Birth Date: ____________________

PRIMARY HEALTHCARE PROVIDER: ______________________________

ADDRESS CITY STATE ZIP CODE

TELEPHONE FAX:

OTHER HEALTHCARE PROVIDER: ______________________________

ADDRESS CITY STATE ZIP CODE

TELEPHONE FAX:

I hereby authorize my child's physician(s) listed above, as well as Zahi Kassass, MD, acting school physician, to exchange the following information with Wellsville Central School Staff, including:

* School Nurse
* Physical Therapist
* Occupational Therapist
* Speech Therapist
* Audiologist
* Vision Department
* Medical orders/evaluations required for therapy needs
* Authorization for medications during the school day or on school trips
* Medical condition/treatment plans that may have an impact in the school environment
* Social History
* Psychological evaluation/reports
* School Social Worker
* School Psychologist
* Physician referral for services (OT/PT)
* Admissions Officer
* Immunizations/physical exams to comply with NYS regulations
* Medical clearances, as needed, following an injury or change in condition

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon obtaining this release; however, in order to plan the most appropriate program for the student, the information may be needed. Specific immunizations per NYS regulations are required for enrollment. This release expires on the last day of enrollment of the above named student in school and may be revoked at any time by sending the request to cancel this permission in writing to the above address. Such revocation will not affect any disclosure made prior to its receipt. Protected health information will not be disclosed without consent per FERPA regulations. **A copy of this release has been provided to me and will be sent to the appropriate providers when requests are made.**

_____ I waive my right to receive a copy of this notice

Print (Parent/Guardian) Signature Date

Relationship to student, if student is under the age of 18

* This form complies with all HIPPA regulations.

Transportation Information

School Year: ____________________

Student's Name: ____________________
LAST, FIRST, MIDDLE (FULL)

Student's Residence: ____________________
NUMBER STREET APT. # or PO BOX

____
TOWN STATE ZIP CODE

Telephone: ____________________
PRIMARY SECONDARY

Adult #1: ____________________
LAST FIRST MIDDLE (FULL)

____
PRIMARY TELEPHONE SECONDARY TELEPHONE

Adult #2: ____________________
LAST FIRST MIDDLE (FULL)

____
PRIMARY TELEPHONE SECONDARY TELEPHONE

Morning or "To" School Transportation:

- ☐ My Student will be self-transported (walking, being dropped-off, etc…)
- ☐ My Student needs to ride the bus from Home (address above)
- ☐ My Student needs to ride the bus from a different address than home:

____
NUMBER STREET APT. #

____
TOWN STATE ZIP CODE

Afternoon or "From" School Transportation:

- ☐ My Student will be self-transported (walking, being picked-up, etc…)
- ☐ My Student needs to ride the bus to Home (address above)
- ☐ My Student needs to ride the bus to a different address than home:

____
NUMBER STREET APT. #

____
TOWN STATE ZIP CODE

Notes:

Wellsville Central School District

Records Request

Name of Student: ______________________________ Date: ____________________

Students Date of Birth: ______________________________

From: Wellsville Central School District
126 West State Street
Wellsville, New York 14895
Telephone: (585) 596-2173
Fax: (585) 596-2177

To:

Fax:

The student listed above has enrolled in the Wellsville Central School District.

Please send or fax all records concerning health information, special physician reports, psychological evaluation, and any other pertinent information for the student to the school circled below:

Wellsville Elementary School
50-98 School Street
Wellsville, New York 14895
Telephone: (585) 596-2104
Fax: (585) 596-2120

Wellsville Secondary School
126 West State Street
Wellsville, New York 14895
Telephone: (585) 596-2160
Fax: (585) 596-2133

Note that parental permission is no longer rquired when authorized school personnel request records according to the Family Education Rights and Privacy Act, Final Rule on Eucation Records, Federal register, July 17, 1976, Vol. 41, No 118, Page (4673). However, Wellsville Central School District does have signatures on file.

Wellsville Central School District

Records Request

Name of Student: ______________________________ Date: ____________________

Students Date of Birth: ______________________________

From: Wellsville Central School District
126 West State Street
Wellsville, New York 14895
Telephone: (585) 596-2173
Fax: (585) 596-2177

To:

Fax:

The student listed above has enrolled in the Wellsville Central School District.

Please send or fax all records concerning grade evaluation, testing, academic, health information, special physician reports, psychological evaluation, and any other pertinent information for the student to the school circled below:

Wellsville Elementary School
50-98 School Street
Wellsville, New York 14895
Telephone: (585) 596-2104
Fax: (585) 596-2120

Wellsville Secondary School
126 West State Street
Wellsville, New York 14895
Telephone: (585) 596-2160
Fax: (585) 596-2133

Please send current Special Education Records and discipline records to the Office of Special Education at:

Wellsville Central School Disitrct
c/o Special Services
126 West State Street
Wellsville, New York 14895
Telephone: (585) 596-2185
Fax: (585) 596-2189
Email: annfanton@wlsv.org

Note that parental permission is no longer rquired when authorized school personnel request records accourding to the Family Education Rights and Privacy Act, Final Rule on Eucation Records, Federal register, July 17, 1976, Vol. 41, No 118, Page (4673). However, Wellsville Central School District does have signatures on file.

Wellsville Central School District

CONSENT FORM FOR ACCESSING MEDICAID INSURANCE TO PAY FOR CERTAIN SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM (IEP)

Dear Parent/ Guardian of: ______________________________

This is to ask your permission (consent) for Wellsville Central School 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) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

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, ______________________________ the parent/guardian of ______________________________, 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 to 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.

* Name
* Date of Birth
* Gender
* Evaluation Results
* IEP Services
* Transportation Logs
* Session Notes
* Written Orders including diagnosis

I give my consent voluntarily and understand that I may withdraw my consent at any time. l 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.

____

Print (Parent/Guardian) Signature Date