Lyncourt Union Free School District
Student Registration Checklist
2707 Court Street
Syracuse, NY 13208
Phone: 315-455-7571 or Fax: 315-455-7573

The registration office is open by Appointment ONLY.

Registration forms can be downloaded from our website (LyncourtSchool.org) or you may call the Main Office to schedule a time to pick up a packet or to have one mailed to you. You MUST be a resident of the Lyncourt Union Free School District to register and attend school at Lyncourt.

Please NO WALK-INS -you must have an appointment.

Proof of Residency (2) (MUST PROVIDE 1 from List A & 1 from List B)

LIST A (1)

- A copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement;
- A statement signed by a third-party landlord, owner, or tenant from whom the parents or person(s) in parental relation leases or with who, they share property within the District.
- Other signed statement from a third-party establishing the parent(s) or person(s) in parental relation's physical presence within the district.

LIST B (1)

- Pay Stub
- Income Tax form
- Utility or other bills
- Membership documents based on residency (e.g., library card
- Voter registration documents
- Official drivers license, learner permit or non-driver identification
- State or other government issued identification or documents
- Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement
- Evidence of custody of the child, including, but not limited to judicial custody orders or guardianship papers.

The District may also require the parent(s) or person(s) in parental relation to provide an affidavit either: (1) indicating that they are the parent(s) with whom the child lawfully resides; or (2) indicating that they are the person(s) in parental relation to the child, over whom they have total and permanent custody and control, whether through guardianship or otherwise.

Proof of Student's Age (Must provide 1)

- Birth Certificate
- Record of Baptism
- Passport
- Medical Records

Immunizations/Physical (Must provide 2)

- Updated / current list of immunizations
- Your child's latest physical is required to complete registration for the following grades: Pre-K, K, 1,3,5,7,9 &11

Parent / Guardian Photo Identification (Must provide 1)

- Driver's License
- Passport

If applicable:

- Proof of guardianship (through court orders) or proof of custody
- Parents of special education students – child's most recent IEP (Individual Education Plan) and any other pertinent records.
- Those with foster children must be accompanied by a social worker and paperwork should include Form DSS 2999 from the County Department of Social Services.

Lyncourt UFSD School District Registration Form

Registration Office
Lyncourt UFSD
2707 Court St Syracuse, NY 13208
Telephone # (315) 455-7571
Registration by Appointment Only
No Walk-in Registrations

Date: _____

Student Information:		
Last Name, First Name, Middle	**Date of Birth**	
		☐ Male ☐ Female
☐ Select if this student is a foster child		

Address Info:	
Student's Residential Address	
_____ Street Address _____ Apt. #	( ) Student's Home Phone
_____ City _____ State _____ Zip Code	( ) Student's Cell Phone
	Student's Email: _____
☐ *Select if this address is a temporary living arrangement*	
☐ *If address is temporary, select if due to loss of housing or economic hardship*	

Name, address and phone of last school attended		
Last School's Name:	Grade:	Year 1st Entered Grade 9: *(if applicable)*
Address:	Phone:	
☐ Select if this student has previously attended Lyncourt School		
☐ Select if this student receives Special Education Services or other Educational Services		

Optional

Dominant Language spoken in the Home	
☐ English	☐ Arabic
☐ Spanish	☐ Somali
☐ Nepali	☐ Karen
☐ Burmese	☐ Karenni
Other (please specify below)	

The question below is optional:
Ethnicity (choose one)
☐ Hispanic/Latino
☐ Not Hispanic/Latino
Race (Choose all that apply regardless of Ethnicity)
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White

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2707 Court St Syracuse, NY 13208
Telephone # (315) 455-7571
Registration by Appointment Only
No Walk-in Registrations

Parent/Guardian:

Parent/Guardian Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: _____

Employer: _____

Parent/Guardian Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
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Email: _____

Employer: _____

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Other Contacts:

Contact Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: _____

Employer: _____

Contact Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: _____

Employer: _____

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Additional Contacts:

Additional Contact Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: _____

Employer: _____

Additional Contact Information:

Last Name, First Name	**Custody? Yes/No**	**Student Lives With? Yes/No**
	Can Pick Up? Yes/No	Receives Mailings? Yes/No

Relationship to Student:

Address Info:

Residential Address

Street Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Mailing Address (If Different)

Phone #	Phone Type	Call Order
( )		
( )		
( )		
( )		
( )		

Email: _____

Employer: _____

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Other Information:

Other Information:

Please let us know if you have any children in your household that have not reached school age yet so we can inform you about programs in the future.

Last Name, First Name: _____ Date of Birth (mm/dd/yyyy): _____ Relationship to student: _____
Last Name, First Name: _____ Date of Birth (mm/dd/yyyy): _____ Relationship to student: _____

Active Military/Reservist Information:

Please let us know if you are currently on active duty in the armed forces or active duty reserves, we are required to track that information and it may provide additional funding to Lyncourt UFSD.

Parent/Guardian Name _____ Parent/Guardian Name _____

Parental Opt-Out:

☐ **I do not** want a district calendar mailed to me each school year in August

Report cards are available on our Student/Parent Portal at http://www.esmschools.org/spp. Select the option below to request that a copy be mailed home.

☐ **I prefer a paper copy** of my child(s) report card.

The Lyncourt School District provides the community with news, photos and videos from our schools as well as information about events, activities and achievements. At times we also share student work.

In addition, Lyncourt UFSD at times releases "directory information" to outside organizations. This includes a student's name, parents' names, participation in recognized school organizations (including positions held, achievements, athletic records and other matters of public knowledge in the community), height and weight of athletes, dates of attendance, degrees, honors and awards.

Lyncourt UFSD provides this information through a variety of mediums including, but not limited to, printed materials (bulletins, newsletters, etc.), the District website and "social media" (Twitter/Facebook, etc.) as well as information shared with the media (TV/radio/newspapers/magazines, etc.) for their use.

Check below if you wish to "opt out" of these communications.

☐ **I do not** want photos or videos of my child or his/her artwork used by the Lyncourt School District on its website, print or social media (Twitter/Facebook, etc.), or released to the media (TV/newspapers for their broadcast, publication, websites and social media) or to other organizations.
☐ **I do not** want my child's directory information to be shared with **third parties.**
☐ **I do not** want my child's directory information to be shared with **military recruiters.**
☐ **I do not** want my child's directory information to be shared with **institutions of higher education.**

Parent/ Guardian Signature: _____ **Date:** _____

Print Name: _____

Health History Form (to be completed for each student by the parent/guardian)

Date _____ Student's Name _____ Date of birth _____

Gender _____ Age _____ Grade _____ School _____

Medicines: Please list all of the prescription and over-the-counter medicines and supplements (herbal & nutritional) that the student is currently taking.

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines (Please list) ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had any discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting or unexplained seizures?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

HEAD INJURY / CONCUSSION	Yes	No
26. Have you ever had a head injury or concussion?		
27. How many concussions have you had?		
28. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
MISSING / SINGLE ORGAN	**Yes**	**No**
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
MEDICAL QUESTIONS	**Yes**	**No**
30. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
31. Have you ever used and inhaler or taken asthma medicine?		
32. Is there anyone in your family who has asthma?		
33. Do you have groin pain or a painful bulge or hernia in the groin area?		
34. Have you had infectious mononucleosis (mono) within the last month?		
35. Do you have any rashes, pressure sores, or other skin problems?		
36. Have you had a herpes or MRSA skin infection?		
37. Do you have a history of seizure disorder?		
38. Do you have headaches with exercise?		
39. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
40. Have you ever been unable to move your arms or legs after being hit or falling?		
41. Do you or someone in your family have sickle cell trait or disease?		
42. Have you had any problems with your eyes or vision?		
43. Have you had any eye injury?		
44. Do you wear glasses or contact lenses?		
45. Do you wear protective eyewear, such as goggles or a face shield?		
46. Do you worry about your weight?		
47. Are you trying to or has anyone recommended that you gain or lose weight?		
48. Are you on a special diet or do you avoid certain types of foods?		
49. Have you ever had an eating disorder?		
50. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
51. Have you ever had a menstrual period?		
52. How old were you when you had tour first menstrual period?		
53. How many periods have you had in the last 12 months?		

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Parent/Guardian _____ Date _____

Lyncourt UFSD School District Registration Form

Medical Background (to be completed for all students by the parent/guardian)

Student's Name _____ **Grade** _____ **Birth date** _____

☐ My child will have a physical with his/her private Health Care Provider.

The following documents are to be completed by a Health Care Provider

1. Section 2 of the Dental Health Certificate (Page 11)
2. Health Appraisal Form (Page 8)

☐ I am requesting a physical examination with the school doctor.

Health Care Provider's Name _____ Phone # _____

Number of children in the family? _____ Position of this child in the family? _____

Has your child had any of the following conditions? Please check and explain all that apply.

	Asthma		Ear Conditions/Defect		Scarlet Fever
	ADD/ ADHD		Eye Conditions/Defect		Seizure Disorder/Epilepsy
	Anemia		Heart Disease		Whopping Cough
	Bleeding Tendency		Kidney Disease		Operations
	Bone / Joint Disease		Nervous Disorder		
	Diabetes		Pneumonia		Serious Injuries
	Allergies: (drug, food, environmental)				

Please explain the checked areas here.

Please list any other serious problems this child has had from birth to present:

Does your child wear: (Please circle all that apply)
Glasses Contact Lenses Hearing Aid(s) Orthodontic (Teeth) Braces
Orthopedic Brace: (Please circle) Right, Left or Both; Wrist, Knee, Ankle, Other body part –

Medication Information

Is this child currently taking medication prescribed by a physician? **YES** / **NO.**
If **YES**, please list below.

Name of Medication	Dose and Frequency	Reason Taking Medication
1.		
2.		
3.		
4.		

Please note: If any medication is to be dispensed during school hours, a Form #2525a, Authorization for Dispensing Medication, must be completed by the student's Health Care Provider *and* parent or guardian and brought to the school nurse with the medication. Form #2525a and additional information can be obtained from the school nurse.

Emergency Information

In the event a parent/guardian cannot be reached, I give my permission for emergency medical treatment to be administered to my son / daughter. Also, I give permission for this information to be given to emergency medical personnel.

_____ _____
Signature of Parent / Guardian Date

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Lyncourt UFSD School District Registration Form

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School:

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

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

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?	❑ Parent 1 _____ *specify*		❑ Parent 2 _____ *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: ❑ Parent ❑ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF 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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Please fill in your and your child's names & sign the bottom of the form even if you DO NOT have MEDICAID. This form will stay in your child's file, and will only be used if/when your child receives special education services.

Lyncourt UFSD
Committee on Special Education
2707 Court Street
SYRACUSE, NY 13208 (3154557571)

Medicaid Consent

Dear Parent/Guardian:

DOB: _____
Client Identification Number (CIN):_____

This is to ask your permission (consent) 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/county to bill for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____as the parent/guardian of _____.
(print name of parent/guardian) ***(please print name of child)***

have received a written notification from the school district/county 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/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or 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 for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

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

Medicaid CIN # ☐☐☐☐☐☐☐☐☐☐ **Or Initial here: _____ My Child is NOT Eligible for Medicaid.**

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Lyncourt Union Free School District
Digital Equity Survey

Student _____ **District** Lyncourt UFSD

Collecting an accurate picture of the digital resources for our New York students will greatly help educators to better serve our students and families. In order to accomplish this, the New York State Education Department is asking parents to complete a Digital Equity survey (for each student in the family) in grades Kindergarten - Grade 12. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, ***please answer each question below*** *and follow any additional instructions provided for submitting or returning the survey. Thank you for your time and cooperation.*

Use blue or black ink.

1. Did the school district issue your child a dedicated school or district owned device for their use during the school year?
   ○ Yes ○ No

2. What is the device your child uses **most often** to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)
   ○ Desktop ○ Chromebook
   ○ Laptop ○ Smartphone
   ○ Tablet ○ No Device

3. Who is the provider of the primary learning device identified in question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork)
   ○ School ○ Personal ○ No Device

4. Is the primary learning device (identified in question 2) shared with anyone else in the household?
   ○ Shared ○ Not Shared ○ No Device

5. Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school?
   ○ Yes ○ No

6. Is your child able to access the Internet in their primary place of residence?
   ○ Yes ○ No

7. What is the primary type of internet service used in your child's primary place of residence?
   ○ Residential Broadband ○ Dial Up
   ○ Cellular ○ DSL
   ○ Mobile HotSpot ○ Other
   ○ Community Wi-Fi ○ None
   ○ Satellite

8. In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment uploads, without interruptions caused by slow or poor internet performance?
   ○ Yes ○ No

9. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?
   ○ Availability ○ Other
   ○ Cost ○ None

Student ID

District ID

"Great Expectations for Achievement, Respect, and Caring"

Lyncourt Union Free School District
2707 Court Street, Syracuse, New York 13208
Phone: (315) 455-7571 Fax: (315) 455-7573
www.lyncourtschool.org

James J. Austin
Superintendent

Kimberly A. Davis
Principal

Cathryn L. Marchese
Business Administrator

Household Income Eligibility Form

Why we need you to fill out the Household Income Eligibility Form when meals are free anyway?

It is important for EVERY family to fill out this form because doing so impacts the amount of aid the district receives. School Aid directly impacts programs for students. Lyncourt School District receives funding from the state and federal governments to support the needs of low-income students. For each student who qualifies for free or reduced-price meals, our district receives thousands of additional dollars in funding. Studies show that many eligible students, in particular middle school and high school students, do not complete this form each year, leaving thousands of dollars in funding for Lyncourt School District on the table.

What if my child doesn't want to eat school lunch? Why should I fill out the form?

Even if your child chooses to bring their own lunch, or goes to a school where all students receive free lunch, filling out the form is very important! It ensures that your school gets all of the funding and benefits available to support teachers and students. In addition, even if your child does not eat school lunch, students who qualify for free lunch also can receive other benefits like:

Discounts for your family on utilities and internet service
Reduced fees for SAT and ACT tests and college applications
Reduced College Application Fees
Future P-EBT Benefits

Is the Information I Submit Confidential?

The information you submit on the Free and Reduced application cannot be shared by the Food Service Department.
Personal information submitted on the form is not shared with the state or federal government: only the number of students who qualify for free or reduced lunch is shared.
Principals and teachers are not told which students qualify for free or reduced lunch benefits.
Lyncourt School District does not share information with other organizations that provide benefits. But if your child does qualify for free or reduced-price lunch, you may use the eligibility form provided by Lyncourt School District to qualify for other benefits through providers like Spectrum Cable and National Grid.

Please call the Food Service Office at (315) 455-7571 ext.4 if you need more information.

Community Eligibility Provision
Household Income Eligibility Form

Lyncourt School District is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call (315) 455-7571 ext. 4 if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: ______________________ CASE #______________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐
	$ ______ / ______	$ ______ / ______	$ ______ / ______	$ ______ / ______	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: Date:

Email Address:

Home Phone

Work Phone

Home Address

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAP/TANF/Foster Income Total Household Income/How Often: Household Size:

Free Eligibility Reduced Eligibility Denied Eligibility

Signature of Reviewing Official

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1 **ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.**

(1) Print the names of the children, including foster children, for whom you are applying on one form.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2 **HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.**

(1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the form in PART 4. **SKIP PART 3 -** Do not list names of household members or income if you list a SNAP, TANF or FDPIR number.

PARTS 3 & 4 **ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.**

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.

PRIVACY ACT STATEMENT

The information provided above is private and intended solely for the use of the Lyncourt Union Free School District.