

# Registering a Student in the Marcellus School District

Welcome to the Marcellus Central School District! Registration for new students takes place in the Central Offices located in Driver Middle School, 2 Reed Parkway. **Please call ahead for an appointment.** Please come to the door marked Business Office. **Office hours are 8 a.m. to 3:45 p.m.** during the school year and **8:45 a.m. – 3:00 p.m.** during school vacations. Please pre-register at [marcelluschools.org/parents/new student registration](http://marcelluschools.org/parents/new-student-registration).

**Please be sure to have all the necessary documents before coming in to register.** If you have any questions, email me (preferable) or call me on the number below.

Sue Larison, Registrar

Tel: 315-673-6000; Fax: 315-673-6034 [slarison@marcelluschools.org](mailto:slarison@marcelluschools.org)

## Forms Needed for Registration

**As a parent, you have the right to refer your child for a special education evaluation if you believe they may have an educational disability. For additional information, please contact the Assistant Superintendent for Pupil Services/CSE chairperson, Trish McCarron [atpmccarron@marcelluschools.org](mailto:atpmccarron@marcelluschools.org) or 673-6006 or go to the NYSED website at [www.p12.nysed.gov/specialed/publications](http://www.p12.nysed.gov/specialed/publications) for a copy of a Parent Guide to Special Education.**

Documentation Detail	Documents on Website	Pertains to:	Completed By:	Check ✓
Registration Form	Word Format Complete & Print	All Students	Parent	<input type="checkbox"/>
Authorization to Release Records Form	Word Format Complete & Print	All Students <i>(except Kindergarten)</i>	Parent	<input type="checkbox"/>

## Forms Needed at time of Registration or within three days of Enrollment

Student Residency Form	Word Format Complete & Print	All Students	Parent	<input type="checkbox"/>
Proof of Residency: (one of each) ➤ Primary Form of Proof ➤ Secondary Form of Proof (see acceptable forms)		All Students who do not have a sibling already in district		<input type="checkbox"/> <input type="checkbox"/>
Proof of Age <i>(birth certificate, passport, health records)</i>		Entering Kindergarten		<input type="checkbox"/>
Up-to-date Immunization Records		All Students	Physician	<input type="checkbox"/>
Physical Exam Form <i>(Physical within 1 year of starting)</i>	PDF Format Print & Complete	All New Students	Physician	<input type="checkbox"/>
Dental Health Certificate (optional)	PDF Format Print & Complete	Students K, 2, 4, 7 & 10	Parent & Dentist	<input type="checkbox"/>
Home Language Questionnaire	PDF Format	All Students	Parent	<input type="checkbox"/>

## If Applicable

IEP/504 Plan		If Special Ed	Outgoing District	<input type="checkbox"/>
Reduced/Free Lunch Form	PDF Format Print & Complete	Those Eligible	Parent	<input type="checkbox"/>
Custody Agreement and/or Court Papers		If parents separated/divorced	Court/Parent	<input type="checkbox"/>
Statement of Residence	Word Format Complete & Print	If living with another family in district – not in own home	Homeowner with whom student is living	<input type="checkbox"/>
Special Transportation Request	Word Format Complete & Print	If parents using childcare address	Parent	<input type="checkbox"/>

# Marcellus Central Schools Student Registration

<b>Student #:</b>		<b>Guidance Counselor/ Homeroom:</b>		<b>Grade Entering:</b>		<b>Date Registered:</b>	
<b>Starting Date:</b>		<b>Home Language Questionnaire:</b> <input type="checkbox"/>		<b>Proof of Residency</b> Primary <input type="checkbox"/> Secondary <input type="checkbox"/>		<b>Siblings in District:</b> <input type="checkbox"/>	
<b>Residency Form:</b> <input type="checkbox"/>		<b>Proof of Age:</b> <input type="checkbox"/>		<b>Physical Exam:</b> <input type="checkbox"/>		<b>Dental Exam:</b> <input type="checkbox"/>	
<b>Authorization to Release Records:</b> <input type="checkbox"/>		<b>K = N/A:</b> <input type="checkbox"/>		<b>Custody Papers/Affidavits:</b> <input type="checkbox"/>		<b>N/A:</b> <input type="checkbox"/>	
						<b>IEP/504 Plan:</b> <input type="checkbox"/> NA <input type="checkbox"/>	
						<b>Entered in ST:</b>	

**Do not write above this line – office use only**

<b>Student's Name</b>		Last		First		Middle		Sex M <input type="checkbox"/> F <input type="checkbox"/>		
Date of Birth				E-mail address:						
Address – House Number & Street:										
City						Zip				
<b>Special Education</b>		Is this child currently identified as a special education student, receiving special education service?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Is this child receiving AIS Services?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Father's Name</b>			DOB			Employer				
Education – Last Grade/Degree					Phone: Home					
Address (if different)					Phone: Cell					
					Phone: Work					
<b>Mother's Name</b>			DOB			Employer				
Education – Last Grade/Degree					Phone: Home					
Address (if different):					Phone: Cell					
					Phone: Work					
Child's Parents are:		Married <input type="checkbox"/>		Separated <input type="checkbox"/>		Divorced <input type="checkbox"/>		Never Married <input type="checkbox"/>		
<b>Child is currently living with:</b> <input checked="" type="checkbox"/>		Father <input type="checkbox"/>		Mother <input type="checkbox"/>		Step-Father <input type="checkbox"/>		Step-Mother <input type="checkbox"/>		
Grandmother <input type="checkbox"/>		Foster <input type="checkbox"/>		Grandfather <input type="checkbox"/>		Legal Guardian <input type="checkbox"/>				
Other, Explain:										

Note: Under Marcellus Central School District Policy: Unless court papers are on file with the district, both parents have equal access to their child(ren) and school records.

## If parent is not available, in case of illness or emergency, call

Name:	Phone: Home
Address:	Phone: Cell
	Phone: Work
Relationship to child:	

Physician		Phone Number:
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## Please list brothers and sisters

Name	Education	Birth Date	Sex: M/F

If this child is transferring from another school, please give the name and address of the former school.

Name:	Address:		
Grade Level student will be entering in Marcellus:			
Has the student ever attended Marcellus in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, when?			

## Preventive and Control Measures

<b>Additional health examinations and date of same:</b>	Chest X-ray
Hearing	Eyes
	Dental
	Other
Is He/She Attending Nursery School/Day Care?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of School:	
Number of Days Attending:	Telephone #

# Health History

Native Language Spoken in the Home:

**State approximate year in which your child had any of the following:**

Chicken Pox	Rheumatic Fever	Tuberculosis
Diphtheria	Scarlet Fever	Contact with TBC
German Measles	Whooping Cough	Measles
Asthma, Allergies	Diabetes	Ear Conditions
Heart Disease	Seizures	Frequent Colds
Mumps	Pneumonia	Operations
Poliomyelitis	Birth Injury	Serious Injuries

Were there any problems with labor and delivery?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
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If yes, please explain:

Birth Weight:	
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Did he/she remain in the hospital after mother's discharge?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
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If yes, please explain:

Does your child have a health problem (allergies, ear problems, etc.) that school personnel should be aware of?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, please explain:

Is your child on any regular medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, please list:

Has your child been hospitalized at all since birth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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If yes, what was the reason?

Has your child had any serious illness or injury that did not require hospitalization?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain:	

Has your child had other screening or evaluation by other health professionals (i.e. speech therapist, neurologist, psychiatrist, etc)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, date and results:	

Do you have any concerns regarding your child that you would like to bring to the attention of his/her teacher or school nurse?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please elaborate:	

I certify that the above information is accurate to the best of my knowledge and that I have legal custody of the above-named child.	
Signature of parent/guardian:	Date:

By completing this part of the form, you will help us to receive any additional state aid that will be made available to our district based on these factors.

**Please answer both questions 1 and 2. Please read them before you respond.**

1. Is the student Hispanic, Latino or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race. Please check  the box that best describes your child.

Yes, Hispanic                       No, not Hispanic

2. Select one or more races from the following five racial groups. For question (2) check  all groups that apply to your child. You must check at least one box.

<p><b>American Indian or Alaska Native:</b> <i>A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.</i> <input type="checkbox"/></p> <p><b>Asian:</b> <i>A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.</i> <input type="checkbox"/></p>	<p><b>Native Hawaiian or Pacific Islander:</b> <i>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.</i> <input type="checkbox"/></p> <p><b>Black:</b> <i>A person having origins in any of the black racial groups of Africa</i> <input type="checkbox"/></p> <p><b>White:</b> <i>A person having origins in any of the original peoples of Europe, North Africa, or the Middle East</i> <input type="checkbox"/></p>
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*Marcellus Central School District  
2 Reed Parkway  
Marcellus, NY 13108  
(315) 673-6000*

## Authorization to Release Records

Permission is hereby given to the school named below:

Name of Previous School:

Address:

Phone No. of School:

Fax No. of School:

To release information to Marcellus Central Schools regarding:

Name:

Date of Birth:

Name:

Date of Birth:

Name:

Date of Birth:

The specific nature or purpose is to obtain information for the student(s) enrolling in our district.

*The Marcellus Central School District is released from all legal responsibility that may arise from this act.*

I, the undersigned, have read the above and authorize the staff of the facility to disclose such information as herein contained.

Signature:

Date:

# Student Residency

Name of Student:

The following questions are asked in accordance with the McKinney-Vento Act 42 U.S.C. 1134a [2] and Education Law 3209 (1)(a). The answers to the following residency questions will provide information to help the Marcellus Central School District determine the services a student may be eligible to receive. 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.

Is the student in temporary living arrangements due to the loss of housing or economic hardship?

Yes  No

If the answer to the above question is yes, please complete the following:

**The student is currently living ...**

**Please check ✓**

- In a household with the custodial parent and/or legal guardian
- In a shelter
- With more than one family or relatives in a house or apartment
- In a place not designed for ordinary sleeping accommodations such as a car, park, or transportation center/station (i.e. train, bus, etc)
- In a motel, hotel, trailer park, camping ground or other similar situation due to the lack of alternative, adequate housing
- In an abandoned apartment/building
- In an Office of Children and Family Services (OCFS) facility awaiting permanent foster care placement
- As a migratory child by moving from place to place
- As an unaccompanied youth for whom no parent or person in parental relation is available

Please answer the following questions. This will help determine whether you are residents of the Marcellus Central School District.

Is the current address and living arrangement in Marcellus the student's actual and only address/residence?

Yes  No

As the parent or legal guardian, is the place you claim as your residence, the place where you and your child sleep, reside, and use as a base of operation?

Yes  No

Does the student intend to remain permanently in the district?

Yes  No

Does the student live with the adult having physical custody (custodian parent or guardian) of the student?

Yes  No

I certify that the information above is correct. I realize that any misrepresentation may lead to the student(s) being denied enrollment in the Marcellus Central School District.

Signature of parent or guardian:

Registrar: If answer to first question is "yes" please give to Liaison. Date:

Initial:

# AGE AND RESIDENCY REQUIREMENTS

## Acceptable Proofs of Residency

It will be necessary for you to provide one form of Primary Proof and at least one form of Secondary Proof. **All forms of proof must be dated within three (3) months of presentation.**

### *Primary proof – show you own or rent property in the district*

#### **OWN your home:**

- ▶ Residential tax bill for improved residential real property within the district, in the name of parent or legal guardian
- ▶ Copy of signed purchase agreement for improved residential real property within the district
- ▶ Residential mortgage instrument, or deed, duly recorded in the Onondaga County Clerk's Office in the name of parent or legal guardian, which describes real property with a residential address within the district.

#### **OR....RENT your home:**

- ▶ Lease agreement and Rental Receipt in the name of parent or legal guardian, for improved residential real property within the district, with name, address, and telephone number of Landlord for verification purposes.
- ▶ Notarized letter from owner of the house stating the parent or legal guardian and student(s) are residing with them. Include the address of the property and utility bill of the owner.

### *Secondary proof – show you actually reside in the district*

- ▶ Utility bill (electricity, telephone, or natural gas or propane) or letter indicating service to begin within 30 days for service at a residential address within the district being billed in the name of Parent or Legal Guardian
- ▶ Bank statement in the name of Parent or Legal Guardian, addressed to a residential address within the district.
- ▶ Social Services correspondence or statement addressed in the name of Parent or Legal Guardian, addressed to a residential address within the district.
- ▶ Social Security correspondence or statement addressed in the name of Parent or Legal Guardian, addressed to a residential address within the district.
- ▶ U.S. Postal Service verification of change of address to a residential address within the district, in the name of Parent or Legal Guardian
- ▶ Federal or NYS income tax documentation with preprinted name and address addressed in the name of Parent or Legal Guardian, addressed to a residential address within the district, such as a W2 form, preprinted label from government, or income tax return check with preprinted address.
- ▶ A policy or binder of homeowner's or residential renter's insurance for residential real property within the district addressed and/or issued in the name of Parent or Legal Guardian.
- ▶ Document issued by federal, state or local agencies (e.g. Federal Office of Refugee Resettlement)
- ▶ Other proof acceptable to a district administrator that would demonstrate that the child actually resides (defined as the primary place where the child predominately sleeps, has a physical presence as an inhabitant, changes clothes, and has a base of operations for their care, custody, and living arrangements in the school district).

## Acceptable Proofs of Age

- ▶ Birth Certificate
- ▶ Passport
- ▶ State or other government issued identification
- ▶ Hospital or health records
- ▶ Consulate identification card
- ▶ Native American tribal document
- ▶ record from non-profit international aid agencies
- ▶ Official driver's license
- ▶ School photo identification with date of birth
- ▶ Military dependent identification card
- ▶ Court order or other court issued documents
- ▶ Document issued by federal, state or local agencies (e.g. local social service agency, federal Office of Refugee Resettlement)



## HEALTH CERTIFICATE / APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal:

Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
 Dental Referral  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_ *Referral*

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Vision - without glasses/contact lenses</td> <td style="width: 10%;">R</td> <td style="width: 10%;">L</td> <td style="width: 20%;"></td> </tr> <tr> <td>Vision - with glasses/contact lenses</td> <td>R</td> <td>L</td> <td></td> </tr> <tr> <td>Vision - Near Point</td> <td>R</td> <td>L</td> <td></td> </tr> <tr> <td>Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td>R</td> <td>L</td> <td></td> </tr> </table>	Vision - without glasses/contact lenses	R	L		Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
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Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

EXAM ENTIRELY NORMAL      Tanner: I. II. III. IV. V.      Scoliosis:  Negative  Positive: \_\_\_\_\_

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

### MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No      Student may self carry and self administer medication  Yes  No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

\_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

\_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: \_\_\_\_\_  None

Known or suspected disability: \_\_\_\_\_  Please monitor

Restrictions: \_\_\_\_\_  Please monitor

Protective equipment required:  Athletic Cup  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

### OPTIONAL INFORMATION, if known

Specify current diseases:  Asthma    Diabetes:  Type 1  Type 2     Hyperlipidemia     Hypertension  
 Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_