
FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET * FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE"

TELEPHONE 518-993-4000

Dear Parent/Guardian,

Welcome to the Fort Plain Central School District! To complete your child's enrollment, we will need the following documentation:

- A copy of your child's **Birth Certificate or Baptismal Certificate**
- **Custody Documentation** (if applicable)
- **Proof of your residency** within the Fort Plain School District (**deed, lease, utility bill**)
- The attached **Enrollment** forms completed

Prompt submission of the above documents to the Main Office will allow us to begin the process of your child's enrollment. Our Superintendent and Principals review the documents you submit.

Once a decision by our administration is made as to whether or not your child's enrollment has been approved, we will contact you.

If you have any questions, please feel free to call our office.



Student Registration Form

(Please Print Clearly)

This form must be completed for each child in the household that is enrolling.

OFFICE USE ONLY

School _____
Date Enrolled _____ Grade _____
Student ID _____
Homeroom _____
Bus # _____

SECTION 1: Student Information

Student's Legal Name _____ Gender: ___ M ___ F

(First Middle Last)
Date of Birth _____ Place of Birth _____ Grade _____

Physical Address _____ Apt. # _____

City _____ Zip _____

Primary Phone Number _____ Text message number _____

This can be landline or cell, but a number where automated messages/attendance calls can be left.)

Previous School Attended _____ City _____ State _____ Zip _____

Has student ever attended Fort Plain CSD before? ☐ Yes ☐ No

What kind of pre-school did the student attend (Pre-K): ___ Home ___ Private Day Care ___ Pre-K Program

Name of Facility: _____ City _____ State _____

Country of Birth _____ Date first entered U.S. School, if born outside U.S. _____

Primary Language Spoken in Household: _____

If registering for grades 9-12, date student completed 8th grade _____

SECTION 2: Special Programs (Please initial in one of the spaces below)

_____ Initial here if student is CURRENTLY participating in any special program listed below

_____ Initial here if student PREVIOUSLY participated in any special program listed below

_____ Initial here if student HAS NEVER participated in any special program listed below

Please indicate which Special Programs student is/has been in:

___ IEP ___ Speech ___ RTI ___ 504 Plan ___ AIS Math ___ AIS Reading ___ Counseling ___ Other

Is there anything you wish to tell us regarding your child, please explain:

Has your student ever been retained? ☐ Yes ☐ No If so, what grade? _____

If your child currently receives services, would you like them to continue to receive these services? ___ Yes ___ No

SECTION 3: Ethnicity/Race

Is student of Hispanic/Latino Ethnicity?

___ Yes ___ No



*Race (Check all that apply): **You MUST check AT LEAST one option**

___ American ___ Indian or Alaska Native ___ Black or African-American
___ Asian ___ Native Hawaiian or Other Pacific Islander ___ White

SECTION 4: Medical Information

List any medical conditions of the student _____

Does this student have any life-threatening food, nut, or insect allergies? _____

Does this student have any medically documented restrictions that would prevent participating in PE?

_____ Yes (must provide a doctor's statement) _____ No

Emergency Medical Authorization:

_____ I, the parent/guardian give permission for emergency medical treatment of my child for illness or accident if a parent/guardian cannot first be contacted or if an ambulance needs to be called.

Doctor's Name: _____ Doctor's Phone: _____

Preferred Hospital: _____

SECTION 5: Custody and Parent/Guardian Information

Student lives with . . .

____ Both Parents ____ Father ____ Mother ____ Grandparent(s) ____ Guardian(s) ____ Foster Parent(s)

____ Alone ____ Other Relative(s) ____ Other, please explain _____

Enrolling Parent/Guardian is: ____ Married ____ Divorced ____ Separated ____ Widowed ____ Single

Is there a custody issue ____ Yes ____ No

Does an order of protection exist? ____ Yes ____ No

(Copy of court order or other legal documents may be required.)

Primary Household Parent/Guardian 1:

Name _____ Cell Phone _____
(First Middle Last)

Employer _____ Work Phone _____

Preferred Email Address _____ Landline Phone _____

Active member of military: ____ Yes ____ No **OR** Member of military reserves: ____ Yes ____ No

Primary Household Parent/Guardian 2:

Name _____ Cell Phone _____
(First Middle Last)

Employer _____ Work Phone _____

Preferred Email Address _____ Landline Phone _____

Active member of military: ____ Yes ____ No **OR** Member of military reserves: ____ Yes ____ No

Is mailing address different than physical address? ____ Yes ____ No

Street or P.O. Box _____

City _____

Zip _____

Secondary Household Information, if applicable (**Applies to parent(s) not living at the same residence as students**)

Secondary Household Parent/Guardian 1

Name _____ Landline Phone _____
 (First Middle Last)
 Employer _____ Cell Phone _____
 Preferred Email Address _____ Work Phone _____

This person is allowed to pick up student from school and can be contacted in the event of an emergency: ____ Yes ____ No
 Active member of military: ____ Yes ____ No **OR** Member of military reserves: ____ Yes ____ No

Secondary Household Parent/Guardian 2:

Name _____ Landline Phone _____
 (First Middle Last)
 Employer _____ Cell Phone _____
 Preferred Email Address _____ Work Phone _____

This person is allowed to pick up student from school and can be contacted in the event of an emergency: ____ Yes ____ No
 Active member of military: ____ Yes ____ No **OR** Member of military reserves: ____ Yes ____ No

Is a double mailing required? If so, please complete the following.

Street Address _____ Apartment # _____
 City _____ Zip _____
 Mailing Address (if different) _____ City _____ Zip _____
 Primary Telephone Number _____ (If only cell phones are used, please provide primary number at which to be contacted)

SECTION 6: Student Information (Include new students enrolling and currently enrolled students)

Please provide the names of all students residing in the primary household, along with the date of birth and relationship to each Parent/Guardian (that is, son, daughter, stepson, stepdaughter, grandchild, sister, brother, etc.).

First Name	Middle Name	Last Name	Date of Birth	Relationship to Primary Household Parent/Guardian 1	Relationship to Primary Household Parent/Guardian 2	Relationship to Secondary Household Parent/Guardian 1	Relationship to Secondary Household Parent/Guardian 2

If there are custody issues that prevent any of the previously indicated heads of household from having access to the students listed above, please provide details. If such restrictions apply to a natural parent or legal parent/guardian, court documentation must be provided.

SECTION 7: Additional Household Members (Please list any other adults living in the Primary Household)

SECTION 8: Emergency Contacts

The following people have permission to pick up my child from school without further contact from me and in the event of an emergency when the Parent/Guardian cannot be reached.

	CONTACT ONE	CONTACT TWO	CONTACT THREE
Name			
Relationship			
Cell Phone			
Work/Landline			
Town of Residence			

SECTION 9: Housing Questionnaire

Where is the student currently living?

- ☐ In permanent housing
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ In a shelter
- ☐ With another family or person due to loss of housing or as a result of economic hardship
- ☐ Other temporary living situation: _____

The answer you gave above will help the district determine what service 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, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

SECTION 10: Parent/Guardian Signature

My relationship to the student is:

- ☐ Parent ☐ Person having lawful Court Order (copy required)
- ☐ Grandparent ☐ Other (Non-Parental Affidavit required)
- ☐ Legal Guardian (documentation needed) ☐ Self/ Student (must be 18 years or older)

I hereby certify that I am either a full-time resident of the Fort Plain school district or am an employee of FPCSD and affirm that all the information contained in this form is true and accurate to the best of my knowledge.

Printed Name _____ Date _____

Signature _____

SECTION 11: Transportation

My student will: ____ Walk ____ Will be picked up ____ Will ride the bus

If your child will be riding the bus:

AM Pick-Up: _____

PM Drop-Off: _____

Enrollment Documents Received:

____ Birth Certificate
____ Records Release
____ Custody Documentation
____ Health Records
____ Report Card
____ SPED Records

FOR SCHOOL USE ONLY

Residency Proof:

____ Lease or Mortgage Statement
____ Utility Bill
____ Other: _____
____ Parent is FPCSD Employee
____ Homeless Statement
____ From Parent

____ IT student account
____ Status Codes
____ Parent Notification
____ Email teachers

Approved: _____ (Principal) Date: _____

Approved: _____ (Superintendent) Date: _____

FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET * FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE"

TELEPHONE 518-993-4000

Dear Parents and Guardians of Fort Plain Students,

On July 1, 2015 an amendment was made to New York State Education Law, pursuant to Chapter 434 of the Laws of 2014, regarding special education parental notification requirements upon a student's entry into school. Section 4402 of the Education Law is an amendment that requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification is provided to parents of all students in the Fort Plain Central School District, with or without disabilities.

This information may be obtained in either of two ways:

1) Follow the link below to *A Parent's Guide to Special Education* on the New York State Education Department's web site,

<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>

2) Obtain a copy of *A Parent's Guide to Special Education* from the main office at Harry Hoag Elementary School or the Junior/Senior High School.

If there are any questions regarding special education and/or the referral process, please contact Fort Plain Central School District's Special Education office. Contact information is as follows:

Brenna Kirkpatrick
Director of Special Education
(518)993-4000 Ext. 3080
brenna.kirkpatrick@fortplain.org

Sincerely,

Brenna Kirkpatrick

Brenna Kirkpatrick
Director of Special Education

Fort Plain Central School District

25 High Street

Fort Plain, NY 13339

Harry Hoag Elementary School

Mrs. Bartholomew, Principal

Fort Plain Jr. /Sr. High School

Mrs. Canallatos, Principal

Student Name _____ DOB _____ Grade _____

Prior School District: _____

Fax _____ Phone _____

Parent Signature _____ Date _____

Does your child currently receive Special Education Services Y N (Please circle)

The above student has registered at Fort Plain Central School. This is to request and authorize the release of the following records and information.

----Current transcript with exiting grades

----IEP / 504 / Remediation / Support Services

---- Standardized Test Scores

----Academic Records

----Health and Immunization Records

----Birth Certificate

----Attendance Records

----Psychological Evaluation

----Custody/Guardianship/Court Orders

----Social History

Date of entry at Fort Plain CSD: _____

Please Email or Fax records to:

PK-6

7-12

Jennifer Ruskowski

Karen Shibley

jennifer.ruskowski@fortplain.org

karen.shibley@fortplain.org

Phone: (518) 993-4000 x 3059

Phone: (518) 993- 4000 x 2124

Fax: (518) 993-4501

Fax: (518) 993-2897

Fort Plain Central School		
Student Name:	DOB:	
School Name:	Age:	
Grade (check): PK K 1 2 3 4 5 6 7 8 9 10 11 12	Limitations: <input type="checkbox"/> NO <input type="checkbox"/> YES	
Sport	Date of last Health Exam:	
Sport Level: <input type="checkbox"/> Modified <input type="checkbox"/> Fresh <input type="checkbox"/> JV <input type="checkbox"/> Varsity	Date form completed:	
MUST be completed and signed by Parent/Guardian - Give details to any YES answers on last page		

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	No	Yes
Ever been restricted by a health care provider from sports participation for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with mononucleosis within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
Have only one functioning kidney?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with hearing or have congenital deafness?	<input type="checkbox"/>	<input type="checkbox"/>
Have any problems with vision or only have vision in one eye?	<input type="checkbox"/>	<input type="checkbox"/>
Have an ongoing medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle cell trait or disease <input type="checkbox"/> Other:		
Have Allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply		
<input type="checkbox"/> Food <input type="checkbox"/> Insect Bite <input type="checkbox"/> Latex <input type="checkbox"/> Medicine <input type="checkbox"/> Pollen <input type="checkbox"/> Other:		
Ever had anaphylaxis?	<input type="checkbox"/>	<input type="checkbox"/>
Carry an epinephrine auto-injector?	<input type="checkbox"/>	<input type="checkbox"/>
BRAIN/HEAD INJURY HISTORY	No	Yes
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Receive treatment for a seizure disorder or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had migraines?	<input type="checkbox"/>	<input type="checkbox"/>

DOES OR HAS YOUR CHILD		
BREATHING	No	Yes
Ever complained of getting extremely tired or short of breath during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Use or carry an inhaler or nebulizer?	<input type="checkbox"/>	<input type="checkbox"/>
Wheeze or cough frequently during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have asthma or exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>
DEVICES / ACCOMMODATIONS	No	Yes
Use a brace, orthotic, or another device?	<input type="checkbox"/>	<input type="checkbox"/>
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid or cochlear implant?	<input type="checkbox"/>	<input type="checkbox"/>
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
DIGESTIVE (GI) HEALTH	No	Yes
Have stomach or other GI problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have a special diet or need to avoid certain foods?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any concerns about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>
INJURY HISTORY	No	Yes
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	<input type="checkbox"/>	<input type="checkbox"/>
Have a bone, muscle, or joint that bothers them?	<input type="checkbox"/>	<input type="checkbox"/>
Have joints that become painful, swollen, warm, or red with use?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been diagnosed with a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>

DOES OR HAS YOUR CHILD		
HEART HEALTH		
Ever complained of:	No	Yes
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness, dizziness, during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain, tightness, or pressure during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Fluttering in the chest, skipped heartbeats, heart racing?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been told by a health care provider they have or had a heart or blood vessel problem?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, check all that apply:		
<input type="checkbox"/> Chest Tightness or Pain <input type="checkbox"/> Heart infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> New fast or slow heart rate <input type="checkbox"/> Kawasaki Disease <input type="checkbox"/> Has implanted cardiac defibrillator (ICD) <input type="checkbox"/> Has a pacemaker <input type="checkbox"/> Other:		

DOES OR HAS YOUR CHILD		
FEMALES ONLY	No	Yes
Have regular periods?	<input type="checkbox"/>	<input type="checkbox"/>
MALES ONLY	No	Yes
Have only one testicle?	<input type="checkbox"/>	<input type="checkbox"/>
Have groin pain or a bulge, or a hernia?	<input type="checkbox"/>	<input type="checkbox"/>
SKIN HEALTH	No	Yes
Currently have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a herpes or MRSA skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19 INFORMATION		
Has your child ever tested positive for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, STOP . Go to Family Heart Health History. If YES , answer questions below:		
Date of positive COVID test:	No	Yes
Was your child symptomatic?	<input type="checkbox"/>	<input type="checkbox"/>
Did your child see a health care provider for their COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child hospitalized for COVID?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HEART HEALTH HISTORY	
A relative has/had any of the following:	
Check all that apply:	
<input type="checkbox"/> Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy <input type="checkbox"/> Arrhythmogenic Right Ventricular Cardiomyopathy? <input type="checkbox"/> Heart rhythm problems, long or short QT interval?	<input type="checkbox"/> Brugada Syndrome? <input type="checkbox"/> Catecholaminergic Ventricular Tachycardia? <input type="checkbox"/> Marfan Syndrome (aortic rupture)? <input type="checkbox"/> Heart attack at age 50 or younger? <input type="checkbox"/> Pacemaker or implanted cardiac defibrillator (ICD)?
A family history of:	
<input type="checkbox"/> Known heart abnormalities or sudden death before age 50? <input type="checkbox"/> Structural heart abnormality, repaired or unrepaired? <input type="checkbox"/> Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?	
If you answered Yes to any Questions, please give details:	

Parent/Guardian Signature:		Date:
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If you answered **YES** to any questions give details. Sign and date below.

[illegible]

Parent/Guardian
Signature: _____

Date:

Parent and Prescriber's Authorization for Administration of Medication in School

A. To be completed by parent/guardian:

I request that my child _____, grade _____
receive the medication as prescribed below by our licensed health care Prescriber. The
medication is to be furnished by me in the properly labeled original container from the pharmacy. I
understand that the school nurse, trained staff (per supervised student), or whom I have
designated, will administer the medication.

Signature (Parent/Guardian) _____

Address _____

Telephone (Home) _____ (Work) _____ Date _____

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication.:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medications: _____

Prescribed Dosage, Frequency and Route of Administration: _____

Time to be taken during the school hours: _____

Duration of Treatment: _____

Possible side effects and adverse reaction (if any): _____

Other recommendations: _____

Please check all that apply:

_____ Supervised Student – can be assisted by trained staff (Student able to identify medication,
knows when, how much, and why they take the medication. They know what happens if
they don't take it and knows when to refuse the medication).

_____ Nurse Dependent Student

_____ Independent Student – can take (self-administer) their own medication without
assistance.

_____ Student takes medication independently in health office (after being handed the
medication container by school staff).

_____ Student is permitted to carry and use medication with the required documentation at
school and sporting events.

Name of Licensed Prescriber and Title (Please Print) _____

Signature: _____ Date: _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

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: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
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☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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:	/ /	Sex: <input type="checkbox"/> Male	Will this be your child's first oral health assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Month Day Year	<input type="checkbox"/> Female		
School: Name				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/ Dental Hygienist

I. The dental health condition of _____ on _____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist'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): _____

II. 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.



**FORT PLAIN
HILLTOPPERS**

School Bus Behavior Contract

RIDE WITH PRIDE

Please read carefully, then sign and return this agreement to your school office within 3 days after receiving the contract.

General Information

- Bus drivers, students, parents, teachers, and school administrators share the responsibility for bus safety, following all bus rules, and behaving in a responsible manner.

☐ **I agree to ride the bus safely.**

Stay seated
Keep aisles free of backpacks
At stops, remain at designated area until bus comes to complete stop

DO NOT put any part of my body outside the window
DO NOT push or shove others
DO NOT leave seat while bus is in motion

☐ **I agree to follow all bus rules and be responsible.**

Keep hands and feet to myself
No eating on the bus
Respect bus property
Sit in assigned seats

DO NOT possess weapons including laser pens
DO NOT possess alcohol, tobacco, or illegal drugs
DO NOT tamper with emergency door or equipment

☐ **I agree to treat the bus, the driver, and all passengers with respect.**

Obey directions from my bus driver
Talk and act kindly to others

DO NOT leave trash, food, etc. on the bus
DO NOT throw, spit, kick or hit
DO NOT use foul language, tease, threaten others, or use inappropriate gestures.

If I choose not to follow this contract, I understand the following consequences may occur, or in the event of a serious offense I may be suspended from the bus immediately:

- #1 My parent(s)/guardian will be notified by an administrator at my school district and I will be warned about the consequences of not following the school bus rules. I understand that other disciplinary measures may include a change in seat assignment, loss of privileges, parent/student conference with district administration, or other actions that are relevant to the offense.
- #2 My parent(s)/guardian will be notified by an administrator and I may lose all bus privileges. If a student loses bus privileges, it is your responsibility to arrange transportation to school to ensure continuity in the student's education.
- #3 Severe Clause: Students may be suspended immediately from the bus for severe infractions for a period of time to be determined by the school administrator. A serious infraction, such as a weapon, drug or physical violence, may result in bus privileges being suspended immediately and further disciplinary actions may occur.

NOTE: If bus privileges are suspended, I must arrange my own transportation to and from school.

Please print legibly. Signatures indicate that you have discussed, understand, and agree to the above statements. Thank you.

Parent/Guardian Name _____

Student Name _____

Parent/Guardian Signature _____

Student's Signature _____

Date: _____

FORT PLAIN CENTRAL SCHOOL DISTRICT

25 HIGH STREET * FORT PLAIN, NEW YORK 13339-1365

"OUR AIM IS EXCELLENCE"

TELEPHONE 518-993-4000

New York State requires school districts to collect information regarding student access to technology. Please complete and return to the main office.

Student's Name _____

Today's Date _____

Student's Grade _____

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.)
 - A. Desktop
 - B. Laptop
 - C. Tablet
 - D. Chromebook
 - E. Smartphone
 - F. Other
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.)
 - A. Personal
 - B. School
 - C. No Device
4. Is the primary learning device (identified in question 2) shared with anyone else in the household?
 - A. No Device
 - B. Shared
 - C. Not Shared
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?
 - A. Residential Broadband
 - B. Cellular
 - C. Mobile Hotspot
 - D. Community WIFI
 - E. Satellite
 - F. Dialup
 - G. DSL
 - H. Other
 - I. None
8. In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, 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?
 - A. Availability
 - B. Cost
 - C. Other
 - D. None



Student Technology Sign-Out Agreement

CORE PRACTICE:

- Technology is to be used for research and school related activities.
- Devices will be carried in protective cases, with care and used responsibly.
- Food and liquids will be kept away from devices.
- Students will ensure their device is charged when not in use.
- Websites and apps used will be relevant to the given assignment topic, and appropriate for school.
- Students will take care of the device as if it were their own.

OUT OF BOUNDS BEHAVIOR:

- Deliberate damage or physical changes to the device.
- Carelessness that may result in accidental damage to the device.
- Cyberbullying.
- Food and drinks near or on the devices.
- Inappropriate videos, sites or content that violate the Fort Plain Central School District Code of Conduct.
- Using the device for activities not related to school work.

LOSS OR DAMAGE:

- If the device or charger is damaged, lost, or stolen, the student and parent are responsible for the cost of the repair or replacement deductible, up to \$100.00.
- Any damage, loss or theft of the property must be reported to the District as soon as possible, and no later than the next school day following the occurrence.
- The District may pursue legal action against any student who willfully, maliciously or unlawfully damages, destroys or steals a District-own device.



Student Technology Sign-Out Agreement

By signing below, I acknowledge the following:

- I have read the expectations listed above, and the official Fort Plain School District Acceptable Use Policy: Student Use of Computerized Information Resources, Policy #7314.
- I have read the limited directory information disclosure provided in the official Fort Plain Central School District Student Directory Information Policy, # 7242.
- I understand that technology access is designed for educational purposes. The Fort Plain School District has taken reasonable steps to control access to the Internet, but cannot guarantee that all controversial information will be inaccessible to students.
- I agree that I will not hold the Fort Plain School District responsible for materials acquired on the device or network. I accept full responsibility for supervision when my child's use is not in a school setting.
- I understand that any violation of the regulations defined in these aforementioned guidelines and policies is unethical, and that violations may constitute the following actions: My child and I may be responsible for the cost of repair or replacement up to \$100.00. My child's privileges may be revoked. School disciplinary action against my child may be taken. Appropriate legal action may be initiated against my child or me.
- I understand that my agreement to these terms will be binding for the remainder of my child's schooling at the Fort Plain Central School District, or until a revised agreement is released and signed.

Name of Child(ren) _____

Grade Level of Child(ren) _____

Parent/Guardian Name (print) _____

Parent/Guardian Signature _____

Date of Signature _____

Emergency School Closing Plan

Student's Name: _____

Address: _____

Should there be an actual school emergency, there would not be time to call parents. This means that a specific plan **MUST** be in place for your child or children.

Please remember- If someone usually meets your child at the end of the school day, this person may not be aware that an emergency has arisen and therefore, would not be outside to meet your child. It is important that you have an alternate plan should this type of situation arise.

Please Choose One:

_____ Dismiss my child to ride the regular bus.

_____ Dismiss my child to ride the bus to an alternate location:

(Name/Location/Phone Number)

_____ Dismiss my child to walk home as usual.

_____ Dismiss my child to the following alternate location:

(Name/Location/Phone Number)

_____ Other dismissal arrangement not shown above:

Please also remember to discuss these alternate plans with the appropriate people involved.

Parent Name and Daytime Phone Number: _____

Signature of Parent

Date



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:
		<input type="checkbox"/> Male
Month	Day	Year
<input type="checkbox"/> Female		
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<input type="checkbox"/> Guardian(s)		_____
			specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			specify

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:



NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for
Prekindergarten Students¹

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other _____

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?

☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?

17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no

If yes, in what language(s)?

19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no

If so, what goals do they describe?

20. Please describe anything special you did to prepare your child to begin Prekindergarten.

ⁱ For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.

STAC ID

The University of the State of New York
 THE STATE EDUCATION DEPARTMENT
 STAC/Medicaid Unit
 Room EB 25, Education Building
 Albany, NY 12234

STAC-202

HOMELESS DESIGNATION

Rev. 11/2022

Designation of School District of Attendance for a Homeless ChildSubmitted by: ☐ Local Dept of Social Services (DSS)☐ Designated School District of Attendance (PSD)**PLEASE READ THE INSTRUCTIONS ON THE REVERSE BEFORE COMPLETING THIS FORM****1. NAME OF CHILD**

LAST NAME

FIRST NAME

2. DATE OF BIRTH

MO / DAY / YR

M.I.

3. GENDER☐ FEMALE☐ MALE☐ NON-BINARY**5. Racial/Ethnic Category of Child (See definitions on reverse side of last page.)**American Ind or
Alaskan Native ☐Asian or
Pacific Isl. ☐Black ☐Hispanic ☐White ☐**7. COMPLETE ADDRESS BEFORE CHILD/FAMILY BECAME HOMELESS****8. COMPLETE ADDRESS OF CURRENT LOCATION**DATE CHILD/FAMILY
PLACED IN TEMPORARY
HOUSING

MONTH DAY YEAR

9. DATE DISTRICT OF ATTENDANCE CHOSEN

MONTH DAY YEAR

10. DATE PLACED IN PERMANENT HOUSING

MONTH DAY YEAR

**6. GRADE LEVEL FOR WHICH
PLACEMENT IS SOUGHT****7A. NYS SCHOOL DISTRICT OF ATTENDANCE BEFORE BECOMING HOMELESS****7B. NYS SCHOOL DISTRICT WHERE LAST ENROLLED****8A. NYS SCHOOL DISTRICT OF CURRENT LOCATION****9A. NYS DESIGNATED DISTRICT OF ATTENDANCE**

One of four school districts may be chosen to provide the education component: the school district of attendance before becoming homeless, the school district where last enrolled, the school district of current location or a school district participating in a Regional Placement Plan. This designation may be changed either prior to the end of the first semester of attendance or within 60 days of making this designation, whichever occurs later.

11. Check the appropriate box if the designated school district of attendance (9A) is different from the district of attendance before becoming homeless (7A) and from the district of current location (8A).

☐ District participating in a Regional Placement Plan OR ☐ District where last enrolled (7B) if it is different from the district where last permanently housed (7A) and the district of current location (8A).

12. NAME OF PARENT OR PERSON IN PARENTAL RELATIONSHIP

AREA CODE

TELEPHONE NUMBER

13. SIGNATURE OF PERSON IN PARENTAL RELATIONSHIP TO CHILD

DATE

IT HAS BEEN REPORTED TO ME THAT THIS CHILD IS UNDER THE AGE OF 21 YEARS AND IS THEREFORE ELIGIBLE FOR EDUCATIONAL SERVICES. THE CHILD HAS BEEN ADVISED OF HIS/HER RIGHT TO DESIGNATE THE SCHOOL DISTRICT OF ATTENDANCE.

14. PRINT NAME OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE

TITLE

15. SIGNATURE OF LOCAL DSS OR SCHOOL DISTRICT REPRESENTATIVE

DATE

16. PLACEMENT COUNTY

Local DSS use only

AREA CODE

TELEPHONE NUMBER

INSTRUCTIONS FOR COMPLETING THE STAC-202 FORM
Designation of School District of Attendance for a Homeless Child

Education of homeless children means 1) a child or youth who lacks a fixed, regular, and adequate night-time residence, including a child or youth who is (i) sharing the housing of other persons due to a loss of housing, economic hardship or a similar reason; (ii) living in motels, hotels, trailer parks or camping grounds due to the lack of alternative adequate accommodations; (iii) abandoned in hospitals, (iv) awaiting foster care placement; or (v) a migratory child, as defined in § 1309(2) of the Elementary and Secondary Education Act of 1965, as amended, who qualifies as homeless under any of the provisions of clauses (i) through (iv) of this subparagraph or subparagraph two of this paragraph; or 2) a child or youth who has a primary nighttime location that is (i) a supervised publicly or privately operated shelter designed to provide temporary living accommodations including, but not limited to, shelters operated or approved by the state or local department of social services, and residential programs for runaway and homeless youth established pursuant to article nineteen-H of the executive law; or (ii) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a child or youth who is living in a car, park, public space, abandoned building, substandard housing, bus or train stations or similar setting.

1. Enter the youth's complete last name and first name.
2. Enter the youth's date of birth.
3. Place a check in the box which identifies the gender of the youth.
4. Item reserved for future use.
5. Place a check in the box which identifies, to the best of your knowledge, the racial/ethnic category with which the youth most closely identifies.

Racial/Ethnic Categories:

American Indian or Alaskan Native - A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Asian or Pacific Islander – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

Black – A person having origins in any of the black racial groups of Africa.

Hispanic – A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

White – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

6. Enter the grade level for which placement is being sought.
7. Enter the complete last permanent address prior to becoming homeless.
- 7A. Enter the name of the school district that served the area where the child resided prior to becoming homeless.
- 7B. Enter the name of the school district where the student was last enrolled. This will be different from 7A if the student was previously temporarily housed in a different district and enrolled in that district as a non-resident homeless student.
8. Enter the complete address of current temporary housing including the name of the shelter if applicable and the date the student moved to the current location. If the location is confidential (for example, if the student is living in a domestic violence shelter), the name and address of the location do not need to be provided.
- 8A. Enter the name of the school district of current location.
9. Enter the date of designation.
- 9A. Enter the name of the designated school district of attendance. One of four districts may be designated to provide the educational component:
 - District of attendance before becoming homeless,
 - District where last enrolled,
 - District of current location of temporary housing, or
 - District participating in a Regional Placement Plan (RPP).
10. Enter, if applicable, the date the child moved to permanent housing and is no longer eligible as a homeless student.
11. If the student attends school in a district participating in a Regional Placement Plan or the district where last enrolled (7B), and that district is different from both the district of attendance before becoming homeless (7A) and the district of current location (8A), check the corresponding box where the student attends school (either the District participating in a Regional Placement Plan or the District where last enrolled).
12. Print the name and telephone number of the designator. The designator can be the parent, person in parental relation, the unaccompanied youth (a youth who meets the definition of homeless and is not in the physical custody of a parent or guardian), or the director of a residential program for runaway and homeless youth if the student is living in such a program.
13. The signature of the designator and current date.
14. Print the name of the local Department of Social Services or School District representative and title.
15. The signature of the local Department of Social Services or School District representative is required attesting that this child has moved to temporary housing. A telephone number is required in case the STAC & Special Aids Unit has questions relating to the information provided.
16. The name of the local Department of Social Services that has placed the child in temporary housing, if applicable.

NOTE: Copies should be distributed to the following:

1. State Education Department, only if designated district of attendance is entitled to reimbursement for educational services pursuant to N.Y. Educ. Law § 3209(3);
2. Designated School District of Attendance;
3. District of Attendance before becoming homeless;
4. District where last enrolled;
5. Parent/Guardian/Unaccompanied youth/director of a residential program for runaway and homeless youth; and
6. Local Department of Social Services, only if placed in temporary housing by DSS.

ParentSquare Tips for Parents

1 Activate Account

Click the link in your invitation email/text or sign up on ParentSquare.com or via the ParentSquare app.

2 Download App

It's easy to stay in the loop with the ParentSquare app. Download it now from the App store or Google Play.

3 Set Preferences

Click your name in the top right to visit your account page and set your notification and language preferences.

4 Get Photos & Files

Click 'Photos & Files' in sidebar to easily access pictures, forms and documents that have been shared with you.

5 Appreciate Posts

Click 'Appreciate' in your email/ app or website to thank a teacher or staff for a post. Teachers love the appreciation.

6 Comment or Reply

Click 'Comment' in app or website to privately ask a question about the post that your teacher or school sent.

7 Participate

Click 'Sign Ups & RSVPs' in the sidebar to see available opportunities. Click bell on top to check your commitments.

8 Join a Group

Click 'Groups' in the sidebar to join a group or committee at your school to participate or to stay up-to-date.

9 Find People

Click 'Directory' in the sidebar to find contact information for teachers and parents (not available at all schools).

10 Get in Touch

Click 'Messages' in the sidebar to privately get in touch with staff, teachers and parent leaders.

Fort Plain Central School District
Pre-Kindergarten Program

2025-2026



Our Mission

The Fort Plain Central School District's Universal Prekindergarten Program is committed to providing all children a safe, nurturing, and developmentally appropriate environment that promotes social-emotional, cognitive, and physical growth, as well as a positive self-image and love of learning. The program helps children begin their educational journeys and ensure they are prepared for kindergarten.

Note: Enrollment is not guaranteed. Should registration interest exceed our enrollment capacity, a **random lottery** to select participants will be conducted.

**Lotteries are designed to ensure equitable access for all families to our Pre-K Program.*

Prerequisites:

- Students must be four years of age on or before Dec. 1 **and** eligible for Kindergarten the following year.
- All required paperwork and mandatory academic screening must be completed to determine eligibility before acceptance into the program.
- Students must attend the program daily unless the student is sick.
- The program will follow all federal and state regulations.

General Information

Harry Hoag Elementary School
25 High Street
Fort Plain, NY 13339
Main Office Phone Number (518) 993-4000 Ext. 3059
www.fortplain.org

Principal: Mrs. Amy Bartholomew

Teachers: Mrs. Stephanie Parkinson and Mrs. Joanne Kennedy

Teacher Assistants: Mrs. Melonie Heroth

UPK Committee Members:

Stephanie Parkinson, Joanne Kennedy, Melonie Heroth, Amy Bartholomew, Kira Swanson, Amber Genova and parents.

Lottery

Enrollment is not guaranteed. If registration interest exceeds our enrollment capacity, a random lottery to select participants will be conducted on the second Thursday of July. A lottery is designed to ensure equitable access for all families to our Pre-K program. Parents/guardians will be notified in writing of their child's enrollment status after the day of the lottery.

Lottery Process:

- Each application will be labeled with a number and that same corresponding number will be placed on a folded paper and placed in a container.
- A neutral staff member will randomly draw papers from the container and announce each number pulled out aloud. The staff member will continue to draw papers until the bowl is empty.
- The Principal will record the order of selection.
 - Ex. Staff announces, "1". Principal records "1" in the #1 spot. Staff member announces, "14". Principal records "14" in the #2 spot.
- The Main Office Secretary will then cross walk the selection list with the applications to create a list of names.

Program Components

A safe, nurturing, and educationally stimulating environment is provided in which learners develop a positive self-image, as well as a strong foundation of social, personal, and readiness skills for the beginning of school. Students are encouraged to grow socially and intellectually through interactions with each other and caring adults and by participating in developmentally appropriate hands-on learning experiences.

The New York State Prekindergarten Learning Standards are organized into five broad developmental and interrelated domains.

A brief description of each domain appears below:

DOMAIN 1: Approaches to Learning

How children become involved in learning and acquiring knowledge.

DOMAIN 2: Physical Development and Health

Children's physical health and ability to engage in daily activities, both outdoors and inside.

DOMAIN 3: Social and Emotional Learning

The emotional competence and ability to form positive relationships that give meaning to children's experiences in the home, school, and larger community.

DOMAIN 4: Communication, Language, and Literacy Part A and Part B

How children understand, create, and communicate meaning.

DOMAIN 5: Cognition and Knowledge of the World (Mathematics, Science, Social Studies, Arts)

What children need to know and understand about their world and how they apply what they know.

Instructional materials and equipment are arranged in learning centers that promote a balance of teacher initiated and child-initiated activities.

Students are screened as new entrants as set forth in the part 117 of the Regulations of the Commissioner.

The required assessments for NYS-funded prekindergarten programs fall into distinct categories: screening new entrants, establishing a developmental baseline (pre-test), progress monitoring, and outcome assessment (post-test). These assessments are required for all prekindergarten students enrolled in district classrooms.

Assessment is the “where are we now” and “where should we go next” of the instructional cycle. There are multiple types of assessment, each with different functions. Assessments used in Pre-k are developmentally appropriate. The assessments screen for social-emotional growth, academic achievement, physical development and mental cognition. The teachers will communicate the results of the assessments. **Students in Pre-k will not be given Standardized Testing.**

School Calendar

Pre-k will follow the regular school calendar for holidays, vacations and emergency closings.

Communication

Fort Plain Central School District uses [Parent Square](#) for to communicate with parents, guardians, students and staff via email, text and app notifications.

It is free to sign up and easy to use.

Visit: [ParentSquare Login/Create Account](#)

Procedures for Student Arrival/Dismissal

Transportation to and from school will be provided by the school bus for any students who are 4 years of age. If your child begins the school year as a 3 year old, he/she must be transported by an adult until he/she comes of age to be eligible to ride the bus per New York State Law.

The school day will run 7:50 -2:30.

For your child's safety, it is required that each person authorized to pick up your child is listed on the appropriate enrollment form. We will not release your child into someone's care who has not been previously authorized by you in writing. We will ask for identification for all newly authorized individuals.

Meals

Students will be provided with breakfast, lunch and a snack. There is no charge for the meals. All meals will be served in the classroom. Please notify the School Nurse and teacher of any allergy concerns.

Health

All students attending UPK must have the required immunizations and proof of blood lead test and physical exam as mandated by State Law. Students will not be allowed to enter the UPK Program without official proof of those immunizations and lead test.

Students who need to take medication prescribed by a physician are eligible for the program. Parents need to provide a note from the doctor giving the School Nurse permission to administer the medication. An adult must transport the medication

to school in a pharmacy labeled container. **Children cannot transport medication.**

If a student exhibits any of the following symptoms, he/she will not be allowed to attend the program for that day. Should your child become sick while attending the program, we will call you to pick your child up immediately.

- Fever of 100 degrees or above
- Earache or drainage from ear
- Vomiting or severe abdominal pain
- Diarrhea
- Unusual fatigue, too sleepy to sit in class
- Severe coughing, sneezing, or thick nasal discharge
- Sore throat that is severe, persisting longer than 48 hours
- Drainage in the eyes
- Unidentified skin rash, crusted sores around mouth and nose

Many of these conditions will require you to check with your healthcare provider. Please keep your child home if any of these symptoms occur. We know how quickly illnesses can be transmitted from child to child. It is important for all children and staff to have a healthy environment in our UPK Program.



Fort Plain Central School PTA Membership Enrollment



Please support the Fort Plain PTA today by joining! The cost for a membership is \$5 per year. These dues support programs for the students, teacher appreciation, and much, much more!

Your membership alone will give us a BIGGER voice in our school and the community! Budget, programs, school events, and volunteer opportunities will be discussed at monthly PTA meetings (attendance is not mandatory but is encouraged).

We would love for you to join us at our next meeting and see all the awesome things that the Fort Plain PTA has to offer!!

Keep in mind that anyone can join the PTA – parents, grandparents, aunts, uncles, close friends, high schoolers, neighbors, church members, etc. are all welcome!

Anyone that has an interest in making your child's potential a reality can join the PTA and help make it possible!



YES, I would like to join the Fort Plain PTA!

Number of memberships: _____ Total: \$_____

Please return this form to school with your student, OR JOIN ONLINE at:

<https://fphilltoppers.memberhub.store/>

Name(s): _____

Address: _____

Phone: _____

E-mail: _____

E-mail addresses are important, as this is how you will get your membership card sent to you. If you do not have an e-mail address, you can still be a member! Please provide an address if possible.

Once your membership is processed, you will have access to the Fort Plain PTA MemberHub, which will allow for easy communication, via the website or convenient mobile app (iPhone or Android apps are available!

