Schalmont
CENTRAL SCHOOL DISTRICT

District Office
4 Sabre Drive, Schenectady, NY 12306
Phone: 518-355-9200 | Fax: 518-355-9203

Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

Dear Families,

Welcome to Schalmont! In this Kindergarten Packet, you will find all the forms you need to register your child.

The first step is to complete the "New Student Registration Form" and contact Registrar Jenn Knight (518-355-9200 ext. 4005 or jknight@schalmont.net) in our District Office. We will schedule an initial registration appointment to review paperwork and answer any questions you may have. Please complete the rest of the forms and bring them to your appointment, along with any necessary documents listed below.

Once your paperwork has been fully reviewed, your child's school will contact you with your child's teacher, bus information, and other details. Again, please feel free to reach out anytime if you have any questions.

Required Documents

Please be prepared to provide **two proofs of residency** when you register your child (note: PO boxes are not acceptable).

Proof 1 – Determine which of the four selections listed below you fall under:

1. **Registrants who are homeowners:**
   - Existing home – Proof of ownership of residential property within the district, such as a deed, a mortgage statement, or a copy of a school tax bill.
   - New home – Copy of sales/building contract including proof of closing date plus photography of new home. If you are not living in the home when registering, a Certificate of Occupancy must be provided within 90 days. Transportation during the transition is the responsibility of the homeowner.
2. **Registrants who are renters:**
   - Signed residential lease agreement for property within the district.
3. **Registrants who are living with another district family:**
   - Statement from the district resident who owns the property that the registering family resides with, using the notarized affidavits (for both families).
4. **Registrants sponsoring a foster child:**
   - A district may also accept other proof such as documentation indicating that the child resides with a sponsor with whom the child has been placed by an agency. Please provide evidence from Department of Social Services, a written statement from the foster parents, and form LDSS 2999.

Proof 2 – One of the following:

- Pay stub, income tax form, utility or other bills
- Voter registration documents
- Official driver's license, learner's permit, or non-driver identification card
- State or other government-issued identification
- Documents issued by federal, state or local agencies (e.g. local Social Services agency, federal Office of Refugee Resettlement)
- Evidence of custody (e.g. court order, guardianship papers)

If you cannot prove the student's residency with a family, you may qualify for McKinney-Vento status (see Student Residency Questionnaire form in packet).

Please be prepared to present the following additional documentation at the time of registration:

- Health records for the student(s)
- Special education information, such as an Individualized Education Plan and most recent psychological evaluation (if applicable)
- Custody papers (if parents are separated, divorced, or not living together)
- A child's certified birth certificate or certified baptism records. If neither are available, school officials may consider the following as evidence of a child's age:
    - Passport
    - Official driver's license
    - Government issued identification
    - School Photo ID with birthdate
    - Consulate ID with birthdate
    - Hospital or Health Records with birthdate
    - Other government issued documents showing age, including court orders and custody papers (e.g. military dependent ID card)
    - Records from non-profit international aid agencies

Schalmont reserves the right to require verification of any documentation provided. All children between the ages of 6 and 21 who have not yet graduated from high school and who are residents of Schalmont Central School District have a right to attend our schools.

If the School Resource Officer verifies that any registration documents have been falsified, written notice will be provided to the parent/guardian stating that the child is not entitled to attend our schools.

Should any questions arise during the registration process, please call the District Office. Thank you!

Sincerely,

Dr. Thomas Reardon
Superintendent

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Kindergarten Registration Checklist

The following forms should be completed and provided during the initial registration appointment:

- ☐ New Student Registration Form
- ☐ Student Residency Questionnaire
- ☐ Census Form (Please do not mail; return in-person with paperwork)
- ☐ Medical-Social Health History Form
- ☐ Health Examination Form
- ☐ Dental Health Certificate
- ☐ Transportation Registration Form
- ☐ Student Racial and Ethnic Identification Form
- ☐ Home Language Questionnaire
- ☐ Chromebook Agreement
- ☐ School Health Services Form
- ☐ Acceptable Use Policy
- ☐ Release of Records Form
- ☐ Application for Free and Reduced Price School Meals/Milk (if applicable)

If registering family is living with a district family, please complete:

- ☐ Affidavits for Residency - In-District Resident (provide a proof of residency) **and** Registering Guardian of New Student

Other Required Documentation:

- ☐ Birth Certificate (or other acceptable documentation to determine child's age)
- ☐ Health/Physical records & Immunization records
- ☐ Special Education information (if applicable)
- ☐ Custody papers (if applicable)

Please don't forget to bring at least two acceptable proofs of residency.

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For office use only
Registration Date: _____
Student ID: _____
Assigned/Advisor/HR/Counselor: _____

NEW STUDENT REGISTRATION FORM

Student Information

Student's Name _____ Gender M / F Pronoun _____ Date of Birth _____ Grade/HR _____

Household Address (House #, Street, City, State, Zip, Apartment or Lot#)
(No P.O. Boxes)_____

Mailing Address (If Different)_____

Priority Household Phone Number:

Is this student a foster child? ☐ Yes ☐ No If yes, attach LDSS2999 Form.

Year Student First Entered 9th Grade (HS only) _____

Previous Enrollment Information

Former Address (House #, Street, City, State, Zip, Apartment or Lot#) _____

Former School _____

Has this student previously attended Schalmont Schools? ☐ Yes ☐ No If yes, when? _____ School _____

Parent/Guardian Information

Parent/Guardian Name _____	**Parent/Guardian Name** _____
Relationship to Student _____	Relationship to Student _____
Legal Guardian: ☐ Yes ☐ No Gender: ☐ Male ☐ Female	Legal Guardian: ☐ Yes ☐ No Gender: ☐ Male ☐ Female
Address (if different from household) _____	Address (if different from household) _____
Occupation _____ Active Duty Military ☐ Yes ☐ No	Occupation _____ Active Duty Military ☐ Yes ☐ No
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Cell Phone: _____ Work Phone: _____	Cell Phone: _____ Work Phone: _____
Home Phone: _____ Email: _____	Home Phone: _____ Email: _____

Siblings (use additional paper if necessary)

Brother/Sister's Name	Date of Birth	School	Grade

 Student's Name _____ Student ID Number _____

Emergency Contacts

Name/Relationship to Student	Address	Phone Number	Relationship to Student

Other Information

Home Language _____ Received English as a Second Language Services? ___Yes ___ No If yes, how many years of ESL _____

Ethnic Group: Please Circle **ONE**:
(Required by ''No Child Left Behind'" Federal Legislation)

Is the student Hispanic, Latino or of Spanish origin?
☐ Yes ☐ No

Circle one or more races from the following racial groups:
Select at least one racial box.

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ African American (Black)
- ☐ Caucasian (White)
- ☐ Native Hawaiian or other Pacific Islander

Health Information

Please list any medications taken daily or as needed at home or school:

_____

_____

_____

_____

_____

Are immunizations up-to-date? ☐ Yes ☐ No
If not, were immunization requirements waived due to:
☐ Medical exemption (attach documentation)

Special Education and Academic Intervention (Remediation) Services

Is your child identified by the Committee on Special Education? Classification _____

Has your child received:

- ☐ Speech and Language
- ☐ Occupational/Physical Therapy
- ☐ Consultant/Resource Room Teacher
- ☐ Self-Contained Classroom
- ☐ BOCES Placement - Where? _____
- ☐ Academic Intervention Services (Remediation) in ☐ Math ☐ Reading ☐ Other _____

(For Office Use Only)

Proof of Residency Displaying Household Address

Required **ONE** from the following:

- ☐ For family living with family: Notarized statement from district homeowner and proof of residency for parent/guardian below
- ☐ Purchase/lease agreement/rent receipt
- ☐ Tax bill (school /property) or Mortgage Statement

And **ONE** from the following:

- ☐ Driver's license, learner's permit
- ☐ Income tax form
- ☐ Pay stub
- ☐ Voter registration card
- ☐ Bank statement
- ☐ Car Insurance
- ☐ Phone bill with household parent's name/address
- ☐ Utility bill with household parent's name/address
- ☐ Birth certificate or passport
- ☐ Custody papers
- ☐ Health Records
- ☐ Last Report Card
- ☐ Special Education (IEP & Psychological Testing)

Parent/Guardian Statement:

I certify that the above information is true and accurate. Any misinformation regarding residency may result in being billed as a tuition-paying student or exclusion from attending the Schalmont Central School District.

Parent/Guardian Signature _____ Date _____

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Student Residency Questionnaire

Note to office staff: Please assist students and families filling out this form as needed

Name of School: _____

Name of Student: _____
Last First Middle

Address: _____

Phone Number: _____ Date of Birth: _____

Age: _____ Grade: _____ Student ID Number: _____

ATTENTION: The answer you provide below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to transportation and other services.

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No

2. Is this temporary living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

If you answered NO, you may stop here.

If you answered YES, please complete the remainder of this form.

Where is the student presently living (check one box)?

- ☐ In a hotel/motel
- ☐ In a shelter
- ☐ With more than one family in a house or apartment
- ☐ In a car, park, bus, train or campsite
- ☐ In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

Print name of parent(s)/legal guardians(s) or student (if unaccompanied youth)

Name: _____

Current Address: _____ Phone: _____

Signature of parent(s)/legal guardian(s) or student: _____

Date: _____

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____
Date McKinney-Vento Liaison Signature

If "yes" was answered above, please send a copy of this form to Nicole Martyn, McKinney-Vento Liaison, in the Schalmont District Office.

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Census Form

The district collects information from residents in order to plan for future student enrollment. The following form should be returned at your registration appointment. (Only one form per family, please).

Name of Household Parent(s)/Guardian(s): _____

Street Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Mailing Address (if different than above): _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Is this address in the Schalmont Central School District? ☐ Yes ☐ No

1. How long have you lived at this address? Years _____ Months _____
2. Previous Address _____

   City _____ State _____ Zip _____
3. Previous School District _____
4. Are you the owner of this residence? ☐ Yes ☐ No If NO, name/address/phone number of landlord:

   Landlord Name _____ Address _____

   City _____ State _____ Zip _____ Landlord Phone _____
5. Is this a multi-family dwelling? ☐ Yes ☐ No If YES, how many units? _____

Please indicate all children (0-18) living at this address. Please list additional children on the back as necessary.

First Name	Middle Name	Last Name	Date of Birth	Preschool Y/N	Grade Enrolling

Registrant/Resident's Signature _____ Date _____

Thank you for your assistance. If you have any questions, please contact Jenn Knight (518-355-9200 ext. 4005 or jknight@schalmont.net) in our District Office.

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Medical-Social Health History Form

Student's Name: _____ Date of Birth: _____

Household Address: _____ Phone: _____

Parent/Guardian Names: _____ _____

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Child Resides with: ☐ Both Parents ☐ One Parent _____ ☐ Other _____
(Indicate Name) (Relationship to Student)

Family Data: Please list immediate family (step-parents, brothers and sisters, step and half siblings) and any other persons living in your household.

Name of Person	Relationship to Student	Date of Birth	Living at Home	
			Yes	No

Please complete as much information on the following form as possible.

Medical Information:

If your child has had any of the following health problems or diseases, please check below and comment as necessary in the space provided.

☐ Allergies ☐ Bee Sting Allergy ☐ Blood Disorders ☐ Chicken Pox ☐ Chronic Ear Infections ☐ Diabetes ☐ Epilepsy	☐ Fainting Spells ☐ Hearing Loss ☐ Heart Disease ☐ Hepatitis ☐ Measles ☐ Mononucleosis ☐ Mumps ☐ Pneumonia	☐ Scarlet Fever/Strep ☐ Seizures ☐ Sickle Cell Disease ☐ Tuberculosis ☐ Vision Problems ☐ Whooping Cough	Comments

1. Please list any of your child's operations, injuries or hospitalizations.

Injury/Accident/Operation	Date

2. Has your child ever had a formal hearing or vision evaluation? ☐ Yes ☐ No

   If yes, please indicate where: _____ Date of evaluation _____

3. Is your child currently taking any medication? ☐ Yes ☐ No

   If yes, please list the medication, dosage, and reason for taking it. _____

   _____

   Please be aware any medication taken in school requires a written order from a physician and written permission from a parent/guardian. This includes over the counter and non-prescription medication.

4. Does your child have a history of frequent: ☐ Upper Respiratory Infections ☐ Ear Infections

   Please indicate: Frequency _____ Medication _____

   Tubes _____ Date(s) _____

5. Does your child have any physical or medical problems that were not listed above that would interfere with his/her school performance? ☐ Yes ☐ No

   If yes, please explain _____

6. Is English the only language spoken at home? ☐ Yes ☐ No

   If no, what other language(s) is spoken at home? _____

7. Please describe your child's usual disposition:

   ☐ Happy ☐ Sad ☐ Shy ☐ Angry ☐ Fearful ☐ Outgoing

8. Please list and explain any specific questions/concerns you may have about your child:

   _____

   _____

   _____

9. Is there any other information about your child or family that will help us understand your child better? (Example: family illness, previous educational problems, new baby, etc.)

   _____

   _____

   _____

Only complete the following section if enrolling a student at Jefferson Elementary School.

Developmental Information:

10. Were there any problems with the pregnancy and/or delivery of your child? ☐ Yes ☐ No

    If yes, please explain _____

    _____

11. Please list the approximate ages that the following occurred:

    Sat Alone: _____ Walked Alone: _____ Said First Word: _____

    Toilet Trained: _____ Talked in phrases (ex. "go bye-bye") _____

12. Does your child have frequent toileting accidents? ☐ Yes ☐ No

    If yes, please describe the frequency and type of problem (bowel/bladder). _____

13. Does your child usually play: ☐ alone ☐ with older children ☐ with younger children

    ☐ with children approximately the same age ☐ next to other children, rather than with the them

14. Approximately how long does your child play with one activity (coloring, blocks, etc.) _____

15. How does your child respond to directions?

    ☐ usually does what adult requests ☐ needs to be asked several times ☐ usually ignores an adult

16. Has your child attended preschool? ☐ Yes ☐ No

    If yes, where and for how long? _____

    Were there any specific teacher recommendations? _____

    _____

For Kindergarten Registration Only:

Do you have any questions or concerns about your child's readiness for kindergarten?

_____

_____

_____

_____

_____

_____

_____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ 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 Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY 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: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, and 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 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: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

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 or Guardian 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.

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Transportation Registration Form 2026-2027

Return to: Schalmont CSD, Transportation Department, 4 Sabre Drive, Schenectady, NY 12306

Student's Name: _____

School _____ Sex: M / F Date of Birth _____ Grade ____

Student's Name: _____

School _____ Sex: M / F Date of Birth _____ Grade ____

Student's Name: _____

School _____ Sex: M / F Date of Birth _____ Grade ____

911 Mailing Address: _____

Actual Residence: *(example: North side of Route 7, two tenths of a mile West of Pangburn Road, 5th house)*

_____

PARENT INFORMATION

Mother's Name: _____ **Father's Name**: _____

Address: _____ Address: _____

_____ _____

Cell Phone: _____ Cell Phone: _____

Home Phone _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

EMERGENCY INFORMATION

Name: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

ALTERNATE LOCATION INFORMATION (If different than above)

Please note, you are limited to one regular alternate drop off/pick up location.

Name & Address of **Pick-Up** Point _____

Days for Pick Up at This Point _____ Phone # _____

Name & Address of **Drop-Off** Point _____

Days for Drop-Off at This Point _____ Phone # _____

To be eligible for transportation to non-public schools, your actual residence must be fifteen (15) miles or less from the non-public school for which you are requesting transportation services to. This form must be completed and returned to the above address no later than April 1, 2026 for non-public schools.

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Student Racial and Ethnic Identification

To Parent/Guardian: Schalmont is required by federal and state law to collect and record the ethnic identity of students in the Schalmont Central School District in accordance with the federal categories and definitions. The information will be used to:

- Report information to New York State and federal Education Departments
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Pease review the Student Racial and Ethnic Identification Form and place a check (✓) in the box for the category or categories which best describes your child. Schalmont understands the sensitive nature of this information and wants to assure you that it will be kept secure and confidential in accordance with all New York State and federal privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, an administrator from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your assistance.

Confidentiality Procedures and Regulations

To School Staff: This form will be filed in the student's permanent record as confidential information.

To Parent/Guardian: This information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below**.

**The Family Education Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Schalmont
CENTRAL SCHOOL DISTRICT

District Office
4 Sabre Drive, Schenectady, NY 12306
Phone: 518-355-9200 | Fax: 518-355-9203

Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

Student Racial and Ethnic Identification Form

All students between 5 and 21 of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.

Name of School:	
Student Last Name, First Name (Middle):	Date of Birth (mm/dd/yyyy)
Grade:	Student ID Number:

Directions to Parent/Guardian:

PLEASE ANSWER QUESTIONS (1) AND (2). Please read them before you respond. For Question 1, check (✓) the box which best describes your child. Check (✓) only **ONE** box.

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.

   ☐ **YES, Hispanic**

   ☐ **NO, Not Hispanic**

   Proceed to Question Number 2

2. Select one or more races from the following five racial groups. Check (✓) ALL the groups that apply to your child. **You MUST check (✓) at least ONE box.**

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

☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example; Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

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

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

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

_____ _____

Signature of Parent/Guardian/Other Date

Relationship to Student: Please check one (✓) box below:

☐ Mother ☐ Father ☐ Guardian ☐ Other (specify) _____

See reverse for important message to Parents/Guardians and Confidentiality Procedures/Regulations

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
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.

Please write clearly when completing this section.

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

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?	❑ Mother _____ *specify*	❑ Father _____ *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: ❑ **Mother** ❑ **Father** ❑ **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

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Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

Schalmont Central School District
Chromebook Agreement

Name of Student (*please print*) _____ **Grade** _____
(first) (last)

Please read and sign, below, acknowledging your understanding and acceptance of the following Chromebook policies. Should damage or loss occur, at anytime, while this device remains assigned to your student you agree to accept responsibility for the following fee(s):

$150 for theft or loss of my student's district assigned Chromebook.

It is understood that the assigned Chromebook, at all times, **remains the property of the Schalmont CSD** and is only to be used for educational purposes as assigned by the classroom teacher. Continuous inappropriate use may result in a loss of privileges and access to these resource(s).

It is understood that my student will **immediately report any loss/theft** to the Help Desk. It is also understood that the district may, at any time, use loss tracking tools to locate and retrieve missing, lost or stolen district Chromebooks.

It is understood that all of my student's **online activities** using their school @schalmont.net account and/or school provided Chromebook are monitored and that all online activities should be for educational purposes.

Should you have multiple students we recommend you remain aware of which Chromebook is assigned to which student.

With my signature, I acknowledge and accept the above policies and understand I will receive an invoice for any incurred fees. There are no fees for device repairs due to normal use or manufacturer defect.

Technology Support: https://sites.google.com/schalmont.net/schalmont-technology/welcome-page

If the Technology Support Page does not answer your needs the Help Desk is available Monday through Friday 7:30 a.m. to 3:30 p.m., excluding holidays. If there are issues with your students' Chromebook the help desk can be reached via email (helpdesk@schalmont.net) or phone (518-355-9200 ext. 3099).

If your student is leaving the district the school provided Chromebook and Charger will need to be immediately returned to the Help Desk.

Print Full Parent/Guardian Name (please print) _____

Parent/Guardian Email _____

Parent/Guardian Phone _____

Parent/Guardian Signature _____

Date _____

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Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

Acceptable Use Policy Form

In order to access information from the Internet and the school network, students must accept responsibility for proper use of these resources. By signing this Acceptable Use Policy, the student agrees to abide by the following rules and regulations of this agreement. **Network users have no expectation of privacy and understand that computer usage is for educational purposes only.**

- Students may access the Internet during supervised class time, study halls or at the school library for research related to their course work.
- Any use of the school network for illegal activity is prohibited.
- Using computer programs which harass users, infiltrate a computing system, or damage software is prohibited.
- Posting of personal information, including pictures, about themselves or other people is prohibited.
- Users will not attempt to gain unauthorized access to the district system or go beyond authorized access.
- Use of profane, obscene, threatening or offensive language in email messages, web pages or social media sites is not permitted.
- Plagiarizing and violating copyright laws are not permitted.
- External e-mail, chat sites, web blogs or journals to communicate with others is not allowed.

Students who engage in unacceptable use may lose access to the District's technology system and may be subject to further disciplinary actions including revocation of computer use and additional consequences as deemed appropriate.

I _____ (*print student name*) have read the above statement and agree to comply with these rules and regulations.

Date: _____

I have read the above with my child and understand the rules my child must adhere to while working with the district's computers. In addition, I give my child permission to use the district's network to access the Internet.

Parent's signature: _____

Date: _____

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Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

School Health Services

Last Name First Name Middle Initial Home Phone

Address Town Zip Birthdate

Last Name Parent/Guardian First Name Employer Cell Phone Day Phone

Last Name Parent/Guardian First Name Employer Cell Phone Day Phone

M ____ F ____
Grade _____
Homeroom # ___
Teacher _____
Students Lives With:
___ Mother
___ Father
___ Step-Mother
___ Step-Father
___ Other

Unless specified, the above two names will be called first in case of an emergency. Please list two others who could be called to pick up your child if needed.

Name Relationship to Student Cell Phone Day Phone

Name Relationship to Student Cell Phone Day Phone

Medical Information

Physician Name Phone Dentist Name Phone

In case of emergency, accident or sudden illness, do you give permission to call the above to treat your child?

Doctor Yes _____ No _____ Dentist Yes _____ No _____

Name of Hospital to use in case of emergency _____

Please list any ongoing medical problems your child may have:

_____

Is your child on daily medications? YES _____ NO ____ If yes, please list:

Medication _____ taken for _____ dose _____ time _____

Medication _____ taken for _____ dose _____ time _____

Is it necessary to have medication in the nurse's office? Yes _____ No _____

If yes, which medication: _____

Medication must be brought to the nurse by the parent in a labeled RX bottle AND with a doctor's note.

Known allergies _____

Does your child have a severe reaction to bee stings? Yes _____ No _____ Unknown _____

If yes, describe the reaction _____ Treatment required _____

Does your child wear glasses/contacts? Yes ____ No _____ Worn for: Reading _____ Distance ____ Always ____

Last physician's eye exam _____ New lenses Yes ____ No ____

Other comments : _____

_____

_____

Parent/Guardian Signature Date

Schalmont
CENTRAL SCHOOL DISTRICT

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Phone: 518-355-9200 | Fax: 518-355-9203

Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

RELEASE OF RECORDS FORM

Student's Name:_____ Grade: _____

Date of Birth:_____ Date: _____

Please Check One:

☐ The above-named student is **transferring to** the Schalmont Central School District from

_____

(Name, Address, and Phone Number of School)

Please check the box of the building your child will be entering:

☐ Jefferson Elementary (Grades K-4)

☐ Schalmont Middle School (Grades 5-8)

☐ Schalmont High School (Grades 9-12)

**** IF YOUR CHILD HAS A CURRENT IEP OR 504 PLAN, PLEASE CHECK MARK THE BOX BELOW****

☐ Schalmont Academic & Instructional Support Services (Grades K-12)

****

As parent/guardian of the above-named student, I give my permission to forward all cumulative records, as indicated below, to the indicated school:

☐ Report cards
☐ Transcript of marks
☐ Standardized test scores
☐ Individual test records
☐ Custody papers
(if parents are separated or divorced)
☐ Screening reports
☐ Special Education/504 documentation records
☐ Personal appraisals and evaluations
☐ Health records and/or other significant medical data
☐ Disciplinary Records
☐ Other _____

If your child is entering the New York State School system for the first time, your child may participate in a screening process to help determine placement. Also, each student must receive a physical examination and will be screened for vision and hearing.

Parent/Guardian(s) Signature: Date: _____

Principal's Signature: Date: _____

Please Fax all records to 518-355-9203

ANNUAL NEWS RELEASE - PUBLIC ANNOUNCEMENT

New York State schools participating in the National School Lunch Program (NSLP) and/or School Breakfast Program (SBP) will offer reimbursable meals to students at no cost. **Schalmont CSD** participates in NSLP.

Free and Reduced Price meal applications may still be collected by your school to determine student eligibility based on the federal income eligibility criteria listed in the chart below.

2026-2027 INCOME ELIGIBILITY GUIDELINES FOR FREE AND REDUCED PRICE MEALS

Free Eligibility Scale						Reduced Price Eligibility Scale					
Free Lunch, Breakfast, Milk						Reduced Price Lunch, Breakfast					
Household Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly	Household Size	Annual	Monthly	Twice per Month	Every Two Weeks	Weekly
1	$ 20,748	$ 1,729	$ 865	$ 798	$ 399	1	$ 29,526	$ 2,461	$ 1,231	$ 1,136	$ 568
2	$ 28,132	$ 2,345	$ 1,173	$ 1,082	$ 541	2	$ 40,034	$ 3,337	$ 1,669	$ 1,540	$ 770
3	$ 35,516	$ 2,960	$ 1,480	$ 1,366	$ 683	3	$ 50,542	$ 4,212	$ 2,106	$ 1,944	$ 972
4	$ 42,900	$ 3,575	$ 1,788	$ 1,650	$ 825	4	$ 61,050	$ 5,088	$ 2,544	$ 2,349	$ 1,175
5	$ 50,284	$ 4,191	$ 2,096	$ 1,934	$ 967	5	$ 71,558	$ 5,964	$ 2,982	$ 2,753	$ 1,377
6	$ 57,668	$ 4,806	$ 2,403	$ 2,218	$ 1,109	6	$ 82,066	$ 6,839	$ 3,420	$ 3,157	$ 1,579
7	$ 65,052	$ 5,421	$ 2,711	$ 2,502	$ 1,251	7	$ 92,574	$ 7,715	$ 3,858	$ 3,561	$ 1,781
8	$ 72,436	$ 6,037	$ 3,019	$ 2,786	$ 1,393	8	$ 103,082	$ 8,591	$ 4,296	$ 3,965	$ 1,983
Each Add'l person, add	$ 7,384	$ 616	$ 308	$ 284	$ 142	Each Add'l person, add	$ 10,508	$ 876	$ 438	$ 405	$ 203

SNAP/TANF/FDPIR Households: Households that currently include children who receive the Supplemental Nutrition Assistance Program (SNAP) but who are not found during the Direct Certification Matching Process (DCMP), or households that currently receive Temporary Assistance to Needy Families (TANF), or the Food Distribution Program on Indian Reservations (FDPIR) must complete an Application for Free and Reduced Price School Meals/Milk, listing the child's name, a valid SNAP, TANF, or FDPIR case number and the signature of an adult household member. Eligibility for free eligibility benefits based on participation in SNAP, TANF or FDPIR is extended to all children in the household. When known to the School Food Authority, households will be notified of their children's eligibility for free benefits based on their participation in the SNAP, TANF or the FDPIR programs. No application is necessary if the household was notified by the SFA their children have been directly certified. If the household is not sure if their children have been directly certified, the household should contact the school.

Other Source Categorical Eligibility: When known to the School Food Authority, households will be notified of any child's eligibility for free eligibility benefits based on the individual child's designation as Other Source Categorically Eligible, as defined by law. Children are determined Other Source Categorically Eligible if they are Homeless, Migrant, Runaway, a foster child, or Enrolled in Head Start or an eligible pre-kindergarten program.

Foster children that are under the legal responsibility of a foster care agency or court, are eligible for free benefits. Any foster child in the household is eligible for free eligibility benefits regardless of income. A separate application for a foster child is no longer necessary. Foster children may also be included as a member of the foster family if the foster family chooses to also apply for benefits for other children. Including children in foster care as household members may help other children in the household qualify for benefits. If non-foster children in a foster family are not eligible for free or reduced-price meal benefits, an eligible foster child will still receive free benefits

If children or households receive benefits under Assistance Programs or Other Source Categorically Eligible Programs and are not listed on the notice of eligibility and are not notified by the School Food Authority of their free meal benefits, the parent or guardian should contact the school or should submit an income application.

Other Households: Households may complete the Application for Free and Reduced-Price School Meals/Milk sent home with the letter to parents. One application for all children in the household should be submitted. Additional copies are available at the principal's office in each school. Applications may be submitted any time during the school year 206/2027 to Maria Zarrillo, Schalmont Food Service Director. Please contact at 518 355-1342 ext. 5069 with any questions regarding the application process.

Households notified of their children's eligibility must contact the School Food Authority if they choose to decline the free eligibility benefits. Households may apply for benefits at any time throughout the school year. Children of parents or guardians who become unemployed or experience a financial hardship mid-year may become eligible for free and reduced-price eligibility at any point during the school year.

Children in households receiving Women, Infants and Children (WIC) benefits may be eligible for free or reduced-price eligibility through the application process.

For up to 30 operating days into the new school year (or until a new eligibility determination is made, whichever comes first) an individual child's free or reduced-price eligibility status from the previous year will continue within the same School Food Authority.

The information provided on the application will be confidential and will be used for determining eligibility. The names and eligibility status of participants may also be used for the allocation of funds to federal education programs such as Title I and National Assessment of Educational Progress (NAEP), State health or State education programs, provided the State agency or local education agency administers the programs, and for federal, State or local means-tested nutrition programs with eligibility standards comparable to the NSLP. Eligibility information may also be released to programs authorized under the National School Lunch Act (NSLA) or the Child Nutrition Act (CNA). The release of information to any program or entity not specifically authorized by the NSLA will require a written consent statement from the parent or guardian.

The School Food Authority does, however, have the right to verify at any time during the school year the information on the application.

Under the provisions of the policy, the designated official will review applications and determine eligibility. If a parent is dissatisfied with the ruling of the designated official, he/she may make a request either orally or in writing for a hearing to appeal the decision. Rachael France, Schalmont CSD Business Administrator,4 Sabre Drive Schenectady, New York 12306 has been designated as the Hearing Official.Hearing procedures are outlined in the policy. However, prior to initiating the hearing procedure, the parent or School Food Authority may request a conference to provide an opportunity for the parent and official to discuss the situation, present information, and obtain an explanation of the data submitted in the application or the decisions rendered. The request for a conference shall not in any way prejudice or diminish the right to a fair hearing.

Only complete applications can be approved. This includes complete and accurate information regarding: the SNAP, TANF, or FDPIR case number; the names of all household members; on an income application, the last four digits of the social security number of the person who signs the form or an indication that the adult does not have one, and the amount and source of income received by each household member. In addition, the parent or guardian must sign the application form, certifying the information is true and correct.

In the operation of child feeding programs, no child will be discriminated against because of race, sex, color, national origin, age, disability or limited English proficiency.

Nondiscrimination Statement: This explains what to do if you believe you have been treated unfairly.
In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW, Mail Stop 9410
   Washington, D.C. 20250-9410; or
2. **fax:**
   (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

Date Withdrew_____ F_____ R_____ D_____

2026-2027 Application for Free and Reduced-Price School Meals/Milk

Schools are required to establish free and reduced-price eligibility while offering meals at no-charge. Please complete the free and reduced-price meals application for your child(ren), then sign and **return it to the address listed below.** Call 518 355-1342 ext.5069 if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: Schalmont Food Service Department Attn: Maria Zarrillo
100 Princetown Road
Schenectady, New York 12306

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

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

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 4 and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you completed step 2)

All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

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
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

***Last Four Digits of Social Security Number:** XXX-XX-__ __ __ __ I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#) or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
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 will get 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: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals benefits.
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race (Check one or more): ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

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 Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid
Signature of Reviewing Official_____ **Date Notice Sent:** _____

APPLICATION INSTRUCTIONS

To apply for free and reduced-price eligibility, complete only one application for your household using the instructions below. Sign the application and return the application to Maria Zarrillo, Schalmont Food Service Director. If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help at 518 355-1342 ext.5069. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

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

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

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

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people **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.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meal benefits. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW, Mail Stop 9410
   Washington, D.C. 20250-9410; or
2. **fax:**
   (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

FREE AND REDUCED PRICE MEAL APPLICATION FACT SHEET

When filling out the application form, please pay careful attention to these helpful hints.

SNAP/TANF/FDPIR case number: This must be the complete valid case number supplied to you by the agency including all numbers and letters, for example, E123456, or whatever combination is used in your county. Refer to a letter you received from your local Department of Social Services for your case number or contact them for your number.

Foster Child: A child who is living with a family but who is under the legal care of the welfare agency or court may be listed on your family application. List the child's "personal use" income. This includes only those funds provided by the agency which are identified for the personal use of the child, such as personal spending allowances, money received by his/her family, or from a job. Funds provided for housing, food and care, medical, and therapeutic needs are not considered income to the foster child. Write "0" if the child has no personal use income.

Household: A group of related or non-related people who are living in one house and share income and expenses.

Adult Family Members: All related and non-related people who are 21 years of age and older living in your house.

Financially Independent: A person is financially independent and a separate economic unit/household when his or her earnings and expenses are not shared by the family/household. Separate economic units in the same residence are characterized by prorating expenses and by economic independence from one another.

Current Gross Income: Money earned or received at the present time by each member of your household before deductions. Examples of deductions are federal tax, State tax, and Social Security deductions. If you have more than one job, you must list the income from all jobs. If you receive income from more than one source (wage, alimony, child support, etc.), you must list the income from all sources. Only farmers, self-employed workers, migrant workers, and other seasonal employees may use their income for the past 12 months reported from their 1040 Tax Forms.

Examples of gross income are:

- Wages, salaries, tips, commissions, or income from self-employment
- Net farm income – gross sales minus expenses only – not losses
- Pensions, annuities, or other retirement income including Social Security retirement benefits
- Unemployment compensation
- Welfare payments (does not include value of SNAP)
- Public Assistance payments
- Adoption assistance
- Supplemental Security Income (SSI) or Social Security Survivor's Benefits
- Alimony or child support payments
- Disability benefits, including workman's compensation
- Veteran's subsistence benefits
- Interest or dividend income
- Cash withdrawn from savings, investments, trusts, and other resources which would be available to pay for a child's meals
- Other cash income

Income Exclusions: 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 Development (Block Grant) Fund should not be considered as income for this program.

If you have any questions or need help in filling out the application form, please contact:

Maria Zarrillo, Schalmont CSD Food Service Director at 518 355-1342 ext.5069 or Mzarrillo@schalmont.net

Schalmont
CENTRAL SCHOOL DISTRICT

District Office
4 Sabre Drive, Schenectady, NY 12306
Phone: 518-355-9200 | Fax: 518-355-9203

Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

Only Complete if Registering Family Is Living with Another District Family
AFFIDAVIT REGARDING RESIDENCY- MUST BE NOTARIZED

DISTRICT HOMEOWNER RESIDENT

STATE OF NEW YORK, COUNTY OF SCHENECTADY

_____, being duly sworn, deposes and says:
(Print full name)

1. I reside at _____, which is within the Schalmont Central School District.
2. I hereby attest that the following people reside at the above address with me (please list all adults and students at this address below).

   _____ _____

   _____ _____

   _____ _____

3. I make this affidavit to induce the District to allow the above named children to enroll in or to continue to attend school in Schalmont and acknowledge that if they do not actually live at this address or any address within the District, that they will not be allowed to continue attendance in Schalmont and that the legal guardians of the children listed may owe the District monies as tuition for their attendance. Approved rates for tuition reimbursement for the 2026-27 school year $10,306 for a Grade Pre-K-6 child and $16,943 for a Grade 7-12 child. This money will be collected in addition to the termination of attendance within the Schalmont Central School District if the information provided is false.
4. I understand that the statements made in this affidavit will be relied upon by the Schalmont Central School District. I swear/affirm that these statements are true under the penalties of perjury, and I understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district may be crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. False statements will be turned over to the Rotterdam Police Department or other police agency.
5. If any of the above information changes, I understand that it is my responsibility to immediately inform the district of these changes.

   _____ (Initial here please)

_____ _____
Resident's Signature Phone Number

Sworn to before me this _____ day of

_____, _____ (Year)

_____
Notary Public

Schalmont
CENTRAL SCHOOL DISTRICT

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Dr. Thomas B. Reardon, Superintendent of Schools, Ext. 4001

Only Complete if Registering Family Is Living with Another District Family
AFFIDAVIT REGARDING RESIDENCY- MUST BE NOTARIZED

PARENT/GUARDIAN OF NON-DISTRICT STUDENT

STATE OF NEW YORK, COUNTY OF SCHENECTADY

_____, being duly sworn, deposes and says:
(Print full name)

1. I am the natural parent of _____.
(full name(s) of child/children)
2. I understand that in order to enroll my child/children as students in the Schalmont Central School District that I and my child/children must reside within the boundaries of the District.
3. I hereby attest that I reside, with my child/children at _____, which is a residence within the boundaries of the Schalmont Central School District.
4. I make this affidavit to induce the District to allow the above named children to enroll in or to continue to attend school in Schalmont and acknowledge that if they do not actually live at this address or any address within the District, that they will not be allowed to continue attendance in Schalmont and that the legal guardians of the children listed may owe the District monies as tuition for their attendance. Approved rates for tuition reimbursement for the 2026-27 school year are $10,306 for a Pre-K-6 child and $16,943 for a Grade 7-12 child. This money will be collected in addition to the termination of attendance within the Schalmont Central School District if the information provided is false.
5. I understand that the statements made in this affidavit will be relied upon by the Schalmont Central School District. I swear/affirm that these statements are true under the penalties of perjury, and I understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district may be crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. False statements will be turned over to the Rotterdam Police Department or other police agency.
6. If any of the above information changes, I understand that it is my responsibility to immediately inform the district of these changes.

_____ (Initial here please)

_____ _____
Resident's Signature Phone Number

Sworn to before me this _____ day of

_____, _____ (Year)

_____
Notary Public