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 the packet is a "New Student Registration Form". Please complete the form and contact (518-355-9200 ext. 4005 or dnotar@schalmont.net) or Debbie Falcone (518-355-9200 ext. 4014 or dfalcone@schalmont.net) in the District Office to make an initial registration appointment.

Required Documents

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

Proof 1 – Determine which of the four selections below that 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 that owns the property that the registrant 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 from the following list:

- Pay stub, income tax form, utility or other bills (dated 30 days prior to registration)
- 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)

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 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

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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Pre K Registration Checklist

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

- ☐ New Student Registration Form
- ☐ Census Form (Please do not mail; return in-person with paperwork)
- ☐ Medical-Social Health History Form
- ☐ Health/Physical records & Immunization records
- ☐ Dental Health Certificate
- ☐ Student Racial and Ethnic Identification Form
- ☐ Home Language Questionnaire
- ☐ Application for Free and Reduced Price School Meals/Milk (if applicable)

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

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

Other Required Documentation:

- ☐ Birth Certificate (or other acceptable documentation to determine child's age)
- ☐ 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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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 2024-25 school year $8372 for a Grade Pre-K-6 child and $18968 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

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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 2024-25 school year are $8372 for a Pre-K-6 child and $18968 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

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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 by mail or fax to the District Office or in-person to any district school. (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 Deb Falcone at 518-355-9200, ext. 4014 or dfalcone@schalmont.net.

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MEDICAL-SOCIAL HEALTH HISTORY FORM

Student's Name: _____ Date of Birth: _____

Household Address: _____ Household 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.)

   _____

   _____

   _____

Complete the following section for students enrolling at Jefferson Elementary School only.

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 IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

STUDENT INFORMATION

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

HEALTH HISTORY

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

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

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

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

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

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

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

PHYSICAL EXAMINATION/ASSESSMENT

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

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

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

☐ **System Review and Exam Entirely Normal**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnosis/Problems (List)	ICD Code

Name:	DOB:

SCREENINGS

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

Recommendations:

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

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

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

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

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

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

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

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

☐ Brace*/Orthotic ☐ Colostomy Appliance* ☐ Hearing Aids

☐ Insulin Pump/Insulin Sensor* ☐ Medical/Prosthetic Device* ☐ Pacemaker/Defibrillator*

☐ Protective Equipment ☐ Sport Safety Goggles ☐ Other:

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

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, & 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'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.

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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

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

To the Parent/Guardian: The Schalmont Central School District 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 Racial/Ethnic definitions on the back of this page. Put a check (✓) in the box for the category or categories which best describes your child. The Schalmont Central School District understands the sensitive nature of this information and wishes 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 cooperation.

Confidentiality Procedures and Regulations

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

To the 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.

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 ❑ Female
Month	*Day*	*Year*	
PARENT/PERSON IN PARENTAL RELATION INFO:			
Last Name	*First Name*	*Relation to*	

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ 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

Date Withdrew_____

Schalmont Central School District

F _ R ____D____

2025-2026 Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and return it to the address listed below. Call Maria Zarillo at 518-355-1342 ext. 5069, if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Jefferson Elementary School**
100 Princetown Road
Schenectady, NY 12306
Attention: Maria Zarrillo

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 answered 'yes' to 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 and provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before it can be approved.

I certify (promise) that all of 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.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: ☐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: _____/_____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid

Signature of Reviewing Official _____ Date Notice Sent _____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, submit a Free Meals Eligibility Letter received from the Office of Temporary and Disability Assistance OR complete only one application for your household using the instructions. Sign the application and return the application to **Jefferson Elementary, 100 Princetown Rd, Schenectady, NY 12306.** If you have a foster child in your household, you may include them on your application. A separate application is no longer needed. **Call the school if you need help: (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 FOOD STAMPS, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current Food Stamp, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. **Do not** use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a food stamp 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) 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 food stamp, TANF or FDPIR number, a social security number is not needed.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). In order 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.

PRIVACY ACT STATEMENT

Privacy Act Statement: This explains how we will use the information you give us.

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, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number are not required when you apply on behalf of a foster child or you list a Food Stamp, 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

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form (PDF), found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
Individuals who are deaf, hard of hearing or have speech disabilities and you wish to file either an EEO or program complaint please contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (in Spanish).
USDA is an equal opportunity employer.