GATES CHILI CENTRAL SCHOOL DISTRICT REGISTRATION FORM

Please *PRINT* all information and complete *BOTH* sides of this form

Student Name: _____ Male _____ Female _____
Last First Middle

Address: _____ Apt. # ____ Zip *146*

Phone# _____ Listed( ) Unlisted( ) Date of Birth _____ Age: _____

Parent/Guardian

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Other

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip

Home Phone#: _____ Pager#: _____

Cell Phone#: _____ Work #: _____

Email Address: _____

Employer: _____

Occupation: _____

Marital Status: ☐Single ☐Married ☐Separated ☐ Divorced ☐Widowed

Relationship to Student: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Foster Parent ☐Group Home Contact ☐Guardian ☐Other

Parent/Guardian

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Other

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip

Home Phone#: _____ Pager#: _____

Cell Phone#: _____ Work #: _____

Email Address: _____

Employer: _____

Occupation: _____

Marital Status: ☐Single ☐Married ☐Separated ☐ Divorced ☐Widowed

Relationship to Student: ☐Mother ☐Father ☐Step Mother ☐Step Father ☐Foster Parent ☐Group Home Contact ☐Guardian ☐Other

Brothers and Sisters (Birth to Age 21)

Name:(Last) (First) (MI)	Sex	Birth Date	Grade	Living at Home	
				Yes	No
				Yes	No
				Yes	No
				Yes	No
				Yes	No

Others in Home:	
Name:	Relationship to Student

Below for Office Use Only

ID# _____ Building _____ Grade _____ Registration Date _____

Records: Date Requested _____ Date Received _____

PLEASE COMPLETE BOTH SIDES

School History

Kindergarten Students Only:

Did your child attend nursery school? (Circle One) **Yes** **No** If yes, for how long? _____

Where? _____
(Name and address of School)

Has your child ever been tested and/or received services for Occupational Therapy___ Physical Therapy___ Speech ___ Other ___

ALL OTHERS:

Name of Last School Attended:_____ Last Grade Attended _____

School Address and Phone # _____

List Other Schools Attended _____

Has child ever played a sport at another Section V school? YES _____ NO _____

If yes, what school/sport/level _____List years_____

Has Student ever repeated a grade? YES ____ NO _____ If yes, which grade? _____

What year did your child **first** enter grade nine? _____

Has Student ever received special help in: Reading _____ Math _____ Speech _____ Other _____

Has student ever been placed in Special Education with an IEP? YES ____ NO ____ If yes, when? _____

Does student have a 504 Plan **YES ____ NO ____**

For more information regarding your rights to special education services, please visit the New York State Education Department's website relating to a parent's guide to special education in New York for children ages three through 21 http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm

Emergency Information

If your child stays with a sitter before and/or after school:

Name of person who cares for student _____ Phone _____

Address_____

If we are unable to reach parents or sitter in an emergency:

Name of Emergency Contact:_____ Phone_____

Address_____Relationship_____

IF THESE TELEPHONE NUMBERS OR THOSE ON THE FRONT OF THIS FORM ARE CHANGED DURING THE YEAR, PLEASE NOTIFY US IMMEDIATELY.

This is to confirm that all of the above information is accurate and that I am a resident of the Gates Chili School District.

_____ _____

Parent/Guardian Signature Date

District Registration/Census Office
Phone: 247-5050 ext. 12224
Fax: 340-5504

Gates Chili Central School District
3 Spartan Way
Rochester, NY 14624

CUSTODY DISCLOSURE FORM

The Registration Office is responsible for registration, **not** in determining which parent or guardian may check a child in/out of school, etc. If custodial or guardianship issues exist when you register your child in the Gates Chili Central School District, it is your responsibility to provide custodial documentation to the Registration Office and a copy will be forwarded to your child's school principal.

Please inform your child's school of changes in custodial arrangements.

Information on Rights of Parents from the Family Education Rights and Privacy Act (FERPA)

An educational agency or institution shall give full rights under the Act to either parent, unless the agency or institution has been provided with evidence that there is a court order, State statute, or legally binding document relating to such matters as divorce, separation or custody that **specifically revokes these rights.**

(Authority: 20 U.S.C. 1232g)

Please check the current custody/guardianship arrangement:

- ☐ 1. Parents/guardians are together residing at the same residence
- ☐ 2. Single parent (father and mother **are** listed on the birth certificate)
- ☐ 3. Single parent (father **is not** listed on the birth certificate)
- ☐ 4. Parents/guardians divorced/separated – joint custody
- ☐ 5. Parents/guardians divorced/separated – sole custody
- ☐ 6. Parents have never been married and have no legal custody papers
- ☐ 7. Custody/guardianship is transferred by courts
- ☐ 8. *Restricted* pickup ***(legal documentation must be provided)***_____
- ☐ 9. Student is *emancipated (legal documentation provided if available)*

Please check all that apply:

- ☐ I have disclosed my current custody/guardianship arrangement.
- ☐ I have attached a copy of those pages of the legal court documents that describe custody arrangements.
- ☐ No legal documents that describe custody arrangements exist.
- ☐ I understand that it is my responsibility to update my child's school principal of changes in custody.

Student Name (please print):_____

_____ _____

Signature of Parent/Guardian Date

Additional Student Identification

All students between 5 and 21 years 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.

Student Name: _____

Please answer all questions. Please read them before you respond. (For question (1) check the box that 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

2. **Select one or more races from the following five racial groups.** (For question (2), check all groups that apply to your child. 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 original peoples of Europe, North Africa, or the Middle East.

3. **Is the student considered an Immigrant Child or Youth?** The term "immigrant children and youth" refers to individuals who:
   - are ages 3 through 21;
   - have not been attending school in any state for more than three full academic years; and
   - were not born in any state.

Immigrant Status: Yes ___ No ___ if yes, Date arrived in United States: _____ Country of Origin:_____

4. **Is the student considered a Migrant Child?**
   Has anyone in your family worked, or looked for work at the following occupations during the past 3 years? (Please check all that apply.)
   - ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
   - ☐ Work related to logging, harvesting, or initial processing of trees.
   - ☐ Work at a food processing plant, (such as meat or poultry processing plants, packaging fruits or vegetables, etc.)

Migrant Status: Yes ____ No ____

Signature of Parent/Guardian_____ Date_____

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

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or 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: *Month* *Day* *Year*

GENDER: ❑ Male ❑ 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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Gates Chili Central School District

PS

3 Spartan Way
Rochester, New York 14624

Nichole Valdez
Registration/Census Clerk

TEL: (585) 247-5050 Ext. 12224
FAX: (585) 340-5504
Email: Nichole_Valdez@gateschili.org

CALL FOR AN APPOINTMENT

Dear Parent(s)/Guardian(s):

Welcome to the Gates Chili Central School District. The enclosed Registration Packet is the **First Step** in completing the registration process. Please take the time to read the forms carefully and fill them out completely. When completed please call to make an appointment to register your child(ren).

	For Office Use Only	
Registration Packet Forms – Please fill out completely prior to appointment	Date Rec'd	Initialed
Proof of Residency Checklist		
Custody Disclosure Form		
Student Registration Form (Complete both sides)		
Student Health History		
Health Appraisal Form	n/a	
Dental Health Certificate	n/a	
HIPPA Form		
Student Records Request	n/a	

Bring these documents to your registration appointment			
When registering your child you need to present Proof of Residency. **Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable please provide at least TWO from Category 2.**			
Residency Proof Category 1	Mortgage Statement; School or Property Tax Receipt; Lease Agreement; Homeowner's/Renter's insurance policy; a statement by a third-party landlord, owner or tenant from whom you lease or with whom you share property within the district; or other statement by a third-party that establishes your physical presence in the District.		
Residency Proof Category 2	• Pay stub • Income Tax Form • Voter registration document(s) • Utility or other bills • Membership documents(e.g., library cards) based upon residency • Official driver's license, learner's permit, non-driver identification, vehicle insurance • State or other government issued identification • Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement) • Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers		
Proof of Age	Birth or baptismal certificate; If not available, then a Passport **If not available, then one of the following:** • Official driver's license • State or other government issued identification • School photo identification with date of birth • Consulate identification card • Hospital or health records • Military dependent identification card • Documents issued by federal, state or local agencies (e.g., local social service agency, federal Office of Refugee Resettlement) • Court orders or other court-issued documents • Native American tribal document • Records from non-profit international aid agencies and voluntary agencies		
Immunization Record signed by Doctor's Office			
Most recent physical			
IEP - Individual Education Plan (if classified) or Declassification Plan or 504 Plan (if applicable)			
Custody or Guardianship Papers (if applicable)			

If you have any questions, please call between 8:00 a.m. and 3:30 p.m. Registration Office 247-5050 ext. 12224.

We look forward to working with you during this enrollment process.

Rev. 11/19/19

GATES CHILI CENTRAL SCHOOL DISTRICT

Student Health History

Student Name _____ Sex_____ Date of Birth_____

Physician's Name _____ Physician Address_____

Has your child ever had any of the following? If "yes" please comment,

	No	Yes	Comment
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Seizures	_____	_____	_____
Bleeding Tendencies	_____	_____	_____
Heart Disease	_____	_____	_____
Tuberculosis Contact	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Severe Headaches	_____	_____	_____
Chicken Pox	_____	_____	_____
Cancer	_____	_____	_____
Leukemia	_____	_____	_____
Vision Problems	_____	_____	_____
Hearing Problems	_____	_____	_____
Speech Problems	_____	_____	_____
Orthopedic Problems	_____	_____	_____
Other	_____	_____	_____

Approximate date of the most recent physical examination _____Exam

Does your child have any allergies to medicine? Yes/No _____
If "Yes" – Type of Reaction

Has your child had any operations (including tonsillectomy)? Yes/No When?_____

Explain _____

Has your child had any serious accidents or injuries? Yes/No When?_____

Explain _____

Is your child now or has he/she ever been on any regular medications? Yes/No When?_____

Explain _____

Does your child have any special health problems or restrictions? Yes/No

Explain_____

Does your child have any allergy to foods? Yes/No (if yes what?)

Explain_____

Does your child have any dietary restrictions? Yes/No (if yes what?)

Explain_____

I give permission for the above health history information to be shared with appropriate school personnel as necessary to promote the health and education of my child.

_____ _____

Date Parent/Guardian Signature

Gates Chili School District

3 Spartan Way
Rochester, NY 14624
(585) 247-5050

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your health care provider will require the release of information form below to share Protected Medical Information with the school district. Please read and sign below.

I, _____, authorize my child's health care provider(s) listed below to release the medical records (including immunizations, health appraisals, and past/current medical conditions and their impact on attendance, school programming, and/or PT/OT/ST needs) of my child, _____, date of birth _____ to the school district's medical officer, physical/ occupational/speech therapist, counselor, social worker, psychologist and/or school nurse.

HC Provider_____Phone_____

HC Provider_____Phone_____

HC Provider_____Phone_____

HC Provider_____Phone_____

The Protected Health Information may be used, disclosed, or received for the purposes of developing care or therapy plans for school management, designing appropriate educational programs, assessing school observations/concerns surrounding behavior and/or student health, assessing a medical basis for modification of transportation and/or tutoring (home or district-based), and medication delivery and/or therapy prescriptions for PT/OT/ST.

This authorization for release of information shall be in force and effect until no longer a student in the Gates Chili School District, at which time this authorization expires.

- I acknowledge that I have the right to revoke this authorization at any time by sending written notification to my health care provider and to the District Administration Building.
- I understand that the revocation of this authorization is not effective if the health care provider or district has used the authorization for the disclosure of Protected Health Information before my written revocation notice.
- I understand that any Protected Health Information disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws may be subject to re-disclosure and may no longer be protected by federal or state law.
- I understand that my child's treatment, payment, enrollment or eligibility for benefits is not dependent on my agreement to release or withhold information.

_____	_____	_____
Date	Signature of parent or guardian, or student over 18	Relationship

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. If you choose *not* to give authorization, please initial here _____ Date _____

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

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

STUDENT INFORMATION

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

HEALTH HISTORY

Allergies ☐ No	☐ 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

Diagnoses/Problems (list)	ICD-10 Code

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

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

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

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

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

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

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

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

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

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

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

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

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

HEALTH CARE PROVIDER

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

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

Gates Chili Central School District

Residency Checklist

Student(s)' Name: _____

In-District Address: _____
House # Street Name Apt. #

Date Registered: _____

These questions are intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help to determine the services the student may be eligible to receive.

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 YES to the above questions, where is the student presently living? (Check one box)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

NOTE: If the student is **not** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required**. Families who are homeless are not required to complete the remaining forms.

Residency Proofs for each family registering students are required by the Gates Chili School District.

Check the box that represents your Residency Status and provide Residency Proofs as listed below.

☐ **Homeowner — Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable please provide at least TWO from Category 2.**
Category 1: Mortgage Statement; School or Property Tax Receipt; Homeowner's insurance policy. (If building new home, Copy of Builder Sales Contract indicating purchaser name, address and tentative completion date.)
Category 2:

- Pay stub
- Income Tax Form
- Utility or other bills
- Voter registration document(s)
- Membership documents(e.g., library cards) based upon residency
- Official driver's license, learner's permit, non-driver identification, or vehicle insurance
- State or other government issued identification
- Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

☐ **Renter — Please provide ONE item from Category 1 and ONE from Category 2. If an item from Category 1 is unavailable please provide at least TWO from Category 2.**
Category 1: Lease Agreement; Renter's insurance policy, statement from landlord or other third-party that establishes physical address in the District.
Category 2:

- Pay stub
- Income Tax Form
- Utility or other bills
- Voter registration document(s)
- Membership documents(e.g., library cards) based upon residency
- Official driver's license, learner's permit, non-driver identification or vehicle insurance
- State or other government issued identification
- Documents issued by federal, state or local agencies(e.g., local social service agency, federal Office of Refugee Resettlement)
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers

☐ **Shared Housing: Sharing Single Family Home or Apartment with Another Family.** **(This section will be completed when the shared housing is not due to loss of residence because of hardship.)*
Primary Resident: Person(s) whose name **is** on the mortgage or lease.
Individual Residing At or Moving In: Person(s) whose name **is not** on the mortgage or lease.

BOTH the "Primary Resident" and the "Individual Residing At or Moving In" must provide Residency Proofs as listed on the back of the Shared Housing Certificate and sign the Shared Housing Certificate.