

Central Registration for MCSD

Maggie Homonchuk, Central Registrar, Marlboro Elementary School
Phone: 845-236-8000 x 1901
Email: maggie.homonchuk@marlboroschools.org

Dear Parent/Guardian,

The Marlboro Central School District registers all students through **Mrs. Maggie Homonchuk**, Central Registrar at the Marlboro Middle School, 1375 Route 9W, Marlboro, NY. **Please make an appointment to register your child or children.**

Please be advised that the building principal or guidance Office will contact you about student placement once the registration process is complete.

Please bring the following items with you, as we cannot process your registration without these documents. In addition to the items below, you need to bring the registration packet. All documents in the packet are available online by clicking the **registration forms** link to the left.

Only Parent or Guardian can register a child in Marlboro Schools. Photo ID will be required at the time of registration.

Student Information Needed to Register

- Original Birth Certificate (Copies not acceptable) , or Original Baptismal Certificate, or Student Passport
- Immunization Record
- Report Card from Previous School [include name, address, and telephone number of school]
- Custody and/or guardianship papers, if applicable

PROOF OF RESIDENCY - (2) Required.

(1) one must be: Mortgage, Deed, or Signed and Notarized Landlord Statement

AND

(1) One of the following: Current Driver's License
Pay Stub dated within 30 days with new address
Voter Registration Card
Social Services check or unemployment check with new address
Current Utility Bill with physical address
Property Tax Bill

registration procedures

MARLBORO CENTRAL SCHOOL DISTRICT
Student Registration Form

Student ID: _____

Registration Date: _____

Grade: _____

This box for school use only.

STUDENT INFORMATION

Last Name

First Name

Middle Name

Gender

DOB: mo/day/yr

Place of Birth: City/State/Country

Date of entry USA

Ethnicity: Choose one: Yes, Hispanic/Latino No, Not Hispanic/Latino

(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.)

Race: Choose one or more:

- American Indian/Alaska Native:** *A person having origins in North America and who maintains cultural identification through tribal affiliation or community recognition. e.g. Cherokee, Mohawk, Inuit.*
- Asian:** *A person having origins in any of the origins of the Far East, Southeast Asia, or the Indian subcontinent.*
- Native Hawaiian/Pacific Islander:** *A person having origins in Hawaii, Guam, Samoa, or other Pacific Islands.*
- Black/African American:** *A person having origins in any of the Black racial groups of Africa.*
- White:** *A person having origins in Europe, North Africa or the Middle East.*

Languages spoken at home: 1. _____ 2. _____

Student Lives with: Both Parents Mother only Father only Foster Parents (documentation required)
 Self Agency (proof of court placement required)

If the student is living with one parent, are there custody papers? Yes No If yes, custody type: _____

Current Living Situation: *Shelter *Motel, hotel, car or campsite due to lack of housing
 *With relatives or others due to lack of housing Home/Apartment

*Please indicate previous address: _____

Educational Background: Previous School Attended: _____

Last Grade: ____ Has your child been retained (repeated a grade)? Yes No If so, what grade? _____

Has your child received: Counseling Speech AIS Reading AIS Math ESOL services

Does your child have a current IEP? Yes No

Other: _____

PARENT/GUARDIAN INFORMATION

Mother's Full Name _____

Father's Full Name _____

Residence Address _____

Residence Address if different _____

Mailing Address if different _____

Mailing Address if different _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Work Phone: _____

Work Phone: _____

Student's Legal Guardian if different from above: _____

Address: _____

Phone Number(s): _____

Siblings Residing at Same Address

Name	Gender	DOB	Grade	Present School

EMERGENCY CONTACT INFORMATION

Local persons who have agreed to pick up your child in an emergency when parents/guardians cannot be reached.

Full Name	Relationship to Student	1 st Phone #	2 nd Phone #

I declare under penalty of perjury, under the laws of the State of New York, that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation.

Parent/Legal Guardian Signature: _____ Date: _____

MARLBORO CENTRAL SCHOOL DISTRICT

Michael Brooks
Superintendent of Schools
845-236-5802

To Whom It May Concern:

The student named below has requested admission into the Marlboro Central School District:

Student's Name: _____ DOB: _____

Please forward the following records for this student as soon as possible. **If appropriate, please forward this release to your Pupil Personnel/Special Education Office.**

- | | |
|--|--|
| <input type="checkbox"/> Attendance Records | <input type="checkbox"/> Science Labs (High School Level) |
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Special Education Records (IEP/504) |
| <input type="checkbox"/> Custody/Guardianship Papers | <input type="checkbox"/> Standardized Test Scores |
| <input type="checkbox"/> Discipline Records | <input type="checkbox"/> Transcript |
| <input type="checkbox"/> Health Records (Immunizations/Physical) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Report Card | _____ |

Name and mailing address of School Previously Attended:

_____ School Phone: _____
_____ School Fax #: _____

Parent/Guardian Signature: _____ Date: _____

Please fax records to:

<input type="checkbox"/> Marlboro High School Guidance Office 50 Cross Road Marlboro, NY 12542 Tel: 845-236-5809 Fax: 845-236-4088	<input type="checkbox"/> Marlboro Middle School Guidance Office 1375 Route 9W Marlboro, NY 12542 Tel: 845-236-5844 Fax: 845-236-7202	<input type="checkbox"/> Marlboro Elementary Student Records 1380 Route 9W Marlboro, NY 12542 Tel: 845-236-1636 Fax: 845-236-1639
<input type="checkbox"/> MCSD Student Services 21 Milton Tpke., Suite 100 Milton, NY 12547 Tel: 845-236-8109 Fax: 845-795-5907	<input type="checkbox"/> MCSD Registrar's Office 1375 Route 9W Marlboro, NY 12547 Tel: 845-236-8000 x1901 Fax: 845-236-3634	<input type="checkbox"/> Other:



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

Lissette Colón-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:		GENDER:
Month	Day	Year
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
			<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
			<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
			<input type="checkbox"/> 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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> NO <input type="checkbox"/> YES	
**DATE OF INDIVIDUAL INTERVIEW: Mo. _____ DAY _____ YR. _____	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> 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: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	



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

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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

*Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas. Gracias.*

Por favor escriba con claridad al completar esta sección.		
NOMBRE DEL ESTUDIANTE:		
Nombre	Segundo nombre	Apellido
FECHA DE NACIMIENTO:		GÉNERO:
		<input type="checkbox"/> Masculino
Mes	Día	Año
		<input type="checkbox"/> Femenino
INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL		
Apellido	Primer Nombre	Relación con el estudiante

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____
			<i>especifique</i>
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____
			<i>especifique</i>
3. ¿Cuál es el idioma primario de cada padre / tutor?	<input type="checkbox"/> Madre	<input type="checkbox"/> Padre	_____
			<i>especifique</i>
	<input type="checkbox"/> Tutor(es)		_____
			<i>especifique</i>
4. ¿Qué idioma o idiomas entiende su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____
			<i>especifique</i>
5. ¿Qué idioma o idiomas habla su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____ <input type="checkbox"/> No sabe hablar
			<i>especifique</i>
6. ¿Qué idioma o idiomas lee su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____ <input type="checkbox"/> No sabe leer
			<i>especifique</i>
7. ¿Qué idioma o idiomas escribe su hijo(a)?	<input type="checkbox"/> Inglés	<input type="checkbox"/> Otro	_____ <input type="checkbox"/> No sabe escribir
			<i>especifique</i>

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

Si* No No se sabe * En caso afirmativo, por favor explique: _____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? Poca gravedad Algo grave Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? No Sí* * Por favor, llene 10b.

10b. *Si se le ha recomendado alguna vez una evaluación, ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?

No Sí – Explique, que forma o formas de educación especial recibió: _____

Edad en la que recibió la intervención o forma de educación especial (favor de marcar todas las opciones que sean aplicables):

De nacimiento a 3 años (Intervención Temprana) 3 a 5 años (Educación Especial) 6 años o mayor (Educación Especial)

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? No Sí

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(Por ejemplo, talentos especiales, problemas de salud, etc.)

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

Mes: Día: Año:

Firma del padre/madre o de la persona en relación paternal

Date

Relación con el estudiante: Madre Padre Otra: _____

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:

MARLBORO CENTRAL SCHOOL DISTRICT

**Michael Brooks
Superintendent of Schools**

The New York State Education Law requires all children in Grades K, 2, 4, 7, 10 and all new entrants to a school system to have a physical examination. It is recommended, however, that every child have an annual examination. The children in the grade levels required to have an exam, may have it done privately by their family doctor or by the school. The school physicals are done by Dr. Mary Dyer, School Physician.

The school physician cannot make as thorough an examination as can your family doctor, who is more familiar with your child's history and environment. If medical care is needed, your physician can arrange for immediate treatment, and he/she will give your child any necessary immunizations. We urge that you have your doctor examine your child and provide us with his/her health appraisal form.

This completed form should be returned to the school nurse-teacher as soon as possible, but no later than two weeks after your child's entrance in school. If the private physician report is not completed, your child will be given a physical examination by the school doctor.

Listed below are the telephone numbers for our school nurses:

Ann Marie Festa, Marlboro High School	236-5808
Janine Beck, Marlboro Middle School	236-5843
Linda Bambaci, Marlboro Elementary School and	
Eileen Bowman, Marlboro Elementary School	236-1637

MARLBORO CENTRAL SCHOOL DISTRICT
Health Office Information Questionnaire - Please be very specific

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name(s): _____ Phone: _____

Family Doctor's Name: _____ Phone: _____

Hospital Preferred: _____

I give the school nurse permission to contact my child's physician in case of a medical emergency or for pertinent medical information.

Parent/Guardian Signature: _____ Date: _____

Has this student had any of the following sicknesses or conditions? If so, please include the dates of each.

Chickenpox: _____	Frequent Colds/Sore Throats: _____
Diabetes: _____	German Measles: _____
Measles: _____	Scarlet Fever: _____
Mumps: _____	Rheumatic Fever: _____
TB or Contact: _____	High Blood Pressure: _____
Pneumonia: _____	Asthmatic Condition: _____
Epilepsy: _____	Whooping Cough: _____
Phobias: _____	Eye/Ear Condition: _____
Convulsions: _____	Frequent Fevers: _____
Orthopedic Problems: _____	
Any Serious Injuries: _____	
Surgeries: _____	
Hospitalizations: _____	

1. Does the student have any vision problems? _____
2. Does the student wear eyeglasses or contact lenses? _____
3. Does the student have any type of hearing problems? _____
4. Does the student have any speech or language problems? _____
5. Does the student have any handicapping conditions? _____
6. Does the student have any emotional special needs? _____
7. Is the student receiving medical treatment of any kind? _____ If so, please explain: _____
8. Is the student receiving any kind of medication and/or herbs? _____ If so, please explain: _____
9. Does the student have any physical limitations or restrictions? _____ If so, please explain: _____
10. Has the student undergone any other screening or evaluation? _____ If so, please explain: _____
11. Are there any other special conditions/allergies or needs that you would like to bring to the School District's attention? _____

For the health and safety of your child this information will be shared with school personnel. Please sign and date this release.

Signature of Parent/Guardian: _____

Date Signed: _____

FOR SCHOOL NURSE USE ONLY BELOW THIS LINE

Are all immunizations complete? _____

If not, which ones are needed? _____

List any special needs: _____

Person taking information: _____

Date: _____

Reviewing Nurse's Initials: _____

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

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

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

Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Vision - without glasses/contact lenses	R	L	Referral
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

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

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

MEDICATIONS

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

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No
 Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

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

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:
 ___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball
 ___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

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

OPTIONAL INFORMATION, if known

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

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination 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 dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: _____		
Last	First	Middle
Birth Date: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
Month Day Year		

School: <small>Name</small> _____	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

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam 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 name and address (please print or stamp) _____ Dentist's Signature _____

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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 1/8 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): _____

- III. 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.

MARLBORO CENTRAL SCHOOL DISTRICT

LANDLORD STATEMENT

Student Name: _____

Grade: _____

Student Name: _____

Grade: _____

Student Name: _____

Grade: _____

Student Name: _____

Grade: _____

This will verify that _____
(Tenant's Name)

Is a tenant residing at the following location: _____

Landlord's Name: _____

Landlord's Address: _____

Landlord's Phone Number(s): _____

Landlord's Signature: _____ Date: _____

State of: _____

County of: _____

Sworn to before me this _____ day

of _____, 20____

Notary Public



MARLBORO CENTRAL SCHOOL DISTRICT



Student Information Form

Date: ____ / ____ / ____

Student's Name: _____
(Last) (First) (MI)

Date of Birth: _____ Gender: _____ Primary Language: _____

Student's Residential Address (No PO Box):

Street: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____ - _____

County of Residence: _____

Parent/Guardian Information:

Guardian Name: _____

Relationship: _____ Employer: _____

Email: _____ Cell: _____

Parent/Guardian Information:

Guardian Name: _____

Relationship: _____ Employer: _____

Email: _____ Cell: _____

Emergency Contact Information:

Emergency Contact: _____

Relationship: _____ Telephone: (____) ____ - _____

Address: _____
(Street) (City) (State) (Zip)



**MARLBORO CENTRAL
SCHOOL DISTRICT**
Bus Permission Form for Students



Note: This form is mandatory for kindergarten, first and second grade students. It is optional for all other students.

STUDENT'S NAME: _____

SCHOOL: _____

I give permission to the below named people to put my child on the bus and/or take my child off of the bus when I am not able to be at his/her bus stop:

<u>NAME</u>	<u>RELATIONSHIP TO CHILD</u>	<u>TELEPHONE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PARENT/GUARDIAN SIGNATURE

DATE

BUS LETTER/ROUTE: A.M. _____ P.M. _____

STOP ASSIGNED: A.M. _____ P.M. _____

OFFICE USE ONLY:

_____ COMPUTER _____ COPY TO DRIVER _____ STAFF INITIALS



MARLBORO CENTRAL SCHOOL DISTRICT



Babysitter Form

This form authorizes parental permission for students to be transported to and from an alternate location, other than the student's home address. This form must be completed and submitted to your child's school office or Quality Bus Service, LLC.

STUDENT'S NAME: _____

SCHOOL/GRADE 2015/2016: _____

HOME ADDRESS:
(Please give home location
- Example: white house, #1216
Route 9W, Marlboro,
New York, 12542

HOME PHONE: _____ **EMERGENCY PHONE:** _____

Marlboro Central School District allows an alternate transportation address on a ***FIVE DAY PER WEEK BASIS ONLY. PLEASE INDICATE YOUR BABYSITTER CHOICE BELOW:***

A.M. (Trip to School) P.M. (Trip Home from School) Both Trips

PLEASE FILL IN THE FOLLOWING PERTINENT BABYSITTER INFORMATION:

BABYSITTER NAME: _____

ADDRESS: _____

TELEPHONE: _____

SIGNATURE PARENT/GUARDIAN: _____

DATE: _____

This form constitutes a public document. Individuals completing this form are advised that the information provided herein must be accurate and true in all respects since the Marlboro Central School District ("the District") will rely on the statements made herein. Any false statements made herein are punishable in accordance with the New York State Penal Law.

MARLBORO CENTRAL SCHOOL DISTRICT

Michael Brooks, Superintendent of Schools
845-236-5802

GENERAL INFORMATION

SCHOOL SCHEDULE

Grades K - 5	8:50 a.m. – 3:30 p.m.
Grades 6 – 8	7:38 a.m. – 2:22 p.m.
Grades 9 – 12	7:42 a.m. – 2:32 p.m.

If a child in the Elementary School walks to school, or is being transported in a manner other than a school bus, he/she should not arrive at school before 8:50 a.m. so that proper supervision can be provided.

ATTENDANCE

Daily school attendance promotes skills for lifelong training. The habit of good attendance tends to carry over into adult, business, and family life. The Marlboro Central School District believes that attendance is a key factor in student achievement. Absence represents an educational loss to the student. To assist you in understanding the New York State Law, the following is a summary from the State Education Department document: Legal Information Concerning School Attendance.

Written excuses are required for all absences. Students are marked illegally absent until a note from the Parent/Guardian is received by the school.

Legal absences include: sickness, family bereavement, religious observance, court appearance.

Illegal absences include: vacation, babysitting, shopping, visiting, oversleeping, truancy, suspension.

Your support is appreciated. Please refer attendance questions to your principal or School Health Office.

EARLY DISMISSAL

- The Superintendent or designee will determine the need for early dismissals. Building principals will notify staff and students.
- Parents/Guardians will be notified through the District's Blackboard Connect System, an automated system that calls home, cell phones, and other numbers designated by the parent/guardian.
- Radio and TV stations will be notified by the Superintendent or designee as follows:
 - FM: 101.5, 106.1, 106.2, 97.7, 92.7, 96.9, 94.3, 97.3, 92.1, 92.9, 93.3, 107.3, 96.1, 100.7, 104.7, 103.7, 97.3, 100.1
 - AM: 1340, 1390, 1450, 920, 1260, 1220, 1490
 - TV: WRNN, FOX

SPECIAL EDUCATION

Parents/Guardians with questions pertaining to the referral and evaluation of their child for the purposes of special education may contact Rosanne Mele, Director of Student Services, at 845-236-8109 or via email: rosanne.mele@marlboroschools.org. A Parent's Guide to Special Education can be accessed at [www.NYSED.gov](http://www.nysed.gov) (<http://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm>) or on the Marlboro Central Schools webpage under the Student Services tab (www.marlboroschools.org)



CONNECT WITH US!

Stay informed about the things happening in the Marlboro Central School District by taking advantage of our new website features and following us on social media.



“Like” us on Facebook at www.facebook.com/marlborocentralschooldistrict



“Follow” us on Twitter @marlborosd



Sign up for the schoolTool Parent Portal to have access to valuable student management data:

- **student grades**
- **attendance**
- **schedules**
- **...and more!**

To log in or register, visit the Parents tab at marlboroschools.org and click “Parent Portal.”



Get emergency notifications or general updates through our Marlboro Alerts auto-notification system. Sign in today to check that your contact information is current and manage your notification settings. Access to this, and other communication platforms, can be found at marlboroschools.org.



IF YOU HAVE ANY QUESTIONS, OR NEED MORE INFORMATION, PLEASE CALL US AT 845-236-8000, EXT. 1300.

MARLBORO CENTRAL SCHOOL DISTRICT
TECHNOLOGY SERVICES
50 CROSS RD
MARLBORO, NY 12542
parentportal@marlboroschools.org

Parent Portal Registration

Student's Name: _____

Building and Grade: _____

Parent Name: _____

Parent's Email: _____

Parent Home Phone: _____

Parent Cell Phone: _____

Voice Text Email

Parent's Signature: _____

Identification Verified Yes _____ No _____

