MARION CENTRAL SCHOOL DISTRICT

Marion's Expectations: Be Respectful, Be Responsible, Be Engaged, and Accept Others' Differences!

REGISTRATION PACKET

Welcome to Marion Central School District! To facilitate a seamless registration process, please ensure you have the following documents and forms ready for submission.

Required Documents:

1. **Two proofs of residency (see residency requirements below)**

RENTER RESIDENCY REQUIREMENTS:	*HOMEOWNER* RESIDENCY REQUIREMENTS:	*LIVING WITH A MARION* RESIDENT REQUIREMENTS:
Current Signed Lease and One Utility Bill **Documents must list name and address on them**	**Mortgage Statement or School Tax Bill. and One Utility Bill** **Documents must list name and address on them**	**Subject to District Residency Official's Approval** ***The district will provide a statement of residency form. This form requires the signature of the homeowner, witnessed by a Notary Public.*** **Along with the statement of residency, please provide:** **1. Proof of Homeowner's Residency** **2. The parent/ guardian of the student also must provide proof of residency at the current address.** **(Example: a cell phone bill, a Credit Card Bill, an Insurance bill or a Driver's License with the new address printed on it, not handwritten on the back).**

2. **Photo Identification of Parent/Guardian** (Driver's license or other government-issued ID)
3. **Proof of Student's Date and Place of Birth**
   - Certified Birth Certificate (from any country)
   - Baptismal record (from any country)
   - A Passport (from any country)
4. **Health Records**
   a. Immunization Records
   b. Last Physical Provided by your Physician's Office (within one year from the start of school)
5. **Legal Custody Documents and/or Court Documents/Orders**
6. *(This is only required if the parents do not live in the same household) If there is no legal documents then the parent affidavit form in the packet needs to be completed and notarized.*

REGISTRATION PACKET FORMS:

- ☐ **Housing Questionnaire**
- ☐ **Student Enrollment Form**
- ☐ **Demographic and Emergency Form**
- ☐ **Student Racial and Ethnic Identification**
- ☐ **Home Language Questionnaire**
- ☐ **Acceptable Use Policy**
- ☐ **Chromebook Policy Signature Page**
- ☐ **Health History/Emergency Information**
- ☐ **HIPPA – Authorization for use of Disclosure of Protected Health Information**
- ☐ **Signed Records Request Form (if transferring from another district)**
- ☐ **Potassium Iodide (KI) Form**
- ☐ **Student Dental Health Certificate- Proof of a dental exam** **(NYS Education Law requires public schools to request a dental health certificate from each student within thirty (30) calendar days of registering or re-enrolling in (1) Pre-KG programs (2) New Entrant or (3) Grades KG, 2, 4, 7 & 10.)**
- ☐ **Opt-Out/Refusal Form for Potassium Iodide Form**
- ☐ **Written Notification Regarding Use of Public Benefits (if appropriate)**
- ☐ **Child Care Provider Form (Elementary School Only)**
- ☐ **Field Trip Permission Form (Elementary School Only)**
- ☐ **Student Transportation Form (if appropriate)**
- ☐ **Authorization for Release of student records**
- ☐ **Health Certificate Appraisal Form (Physical)**
- ☐ **Include Immunization History (Form from Dr.)**

HOUSING QUESTIONNAIRE

Name of LEA: Marion Central School District

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Date of Birth: _____/_____/_____ Grade:_____ ID#_____(Office Use)
Month Day Year

- o **Male**
- o **Female**
- o **Non-binary**

Address: _____ Phone: _____

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

Where is the student currently living? (*Please 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

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

Date: _____

STUDENT ENROLLMENT DATA FORM

Grade: _____ **Student #: _____**

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ Birth City: _____ Birth State: _____
(MM/DD/YYYY)

Gender:
□ **Male**
□ **Female**
□ **Non-binary**

Has the student ever been identified as having a disability (CSE or CPSE)?

_____Yes or ____No

If yes, please describe_____

CUSTODY INFORMATION

Custody? □ Yes □ No **If Yes, please indicate type & provide documentation**

Type of Custody: □ SOLE □ JOINT □ TEMPORARY □ EMPANCIPATED MINOR □ FOSTER □ COURT ORDER
□ PROTECTION ORDER □ OTHER_____

PRIOR SCHOOLS ATTENDED BY STUDENT

(Please include most recent Grade & School – District Name, Building Name, Grade Level(s), and School Year)

PARENT/GUARDIAN INFORMATION

_____ □ Parent □ Stepparent □ Guardian □ Other: _____
(Last Name, First Name)

_____ □ Parent □ Stepparent □ Guardian □ Other: _____
(Last Name, First Name)

Military Service: Are any parents/guardians on active duty in the Armed Forces?
□ Yes □ No Who: □ Parent □ Step-Parent □ Guardian □ Other

SIBLINGS (Birth to 18/21) at this Residence

Name (Last, First, Middle Name)	Relation	Date of Birth	Gender	Birth City & State	Grade/School

PREVIOUS MARION CENTRAL ENROLLMENT

Has this child PREVIOUSLY ATTENDED Marion Central? □ Yes □No If YES, Date/Grade/Building: _____
Was child ENROLLED at Marion with a Different Name? □ Yes □ No If YES, please note below:

Last Name: _____ First Name: _____ Middle Name: _____

Residential Address: _____

PRIOR Mailing Address in MCSD: _____

DEMOGRAPHIC & EMERGENCY CONTACT INFORMATION FORM

Student Name (Last, First, Middle)	Gender	DOB: (MM/DD/YYY)	Grade	Student ID# (Office Use)

	PARENT/GUARDIAN INFORMATION	
	□ Parent □ Guardian	□ Parent □ Guardian
Name (Last, First, MI)		
Maiden Name		
Relationship to Student		
Home Address		
Mailing Address (if different from above)		
Home Phone #		
Cell Phone #		
Work Phone#		
Email Address		
Occupation		
Employer's Name		
Work Hours		
Contact Allowed w/Child	□ Yes □ No	□ Yes □ No
Receives Mail?	□ Yes □ No	□ Yes □ No

ALTERNATE PERSONS TO CONTACT IN AN EMERGENCY

(Please list below any persons OTHER THAN PARENT/GUARDIAN who are authorized to pick up and sign out this student)

	Contact #1	Contact #2	Contact #3
Name			
Relationship			
Home Phone #			
Cell Phone #			

The Undersigned Affirms That the Information Provided Herein Is True and Accurate As Stated

Name: _____ Signature: _____ Date: _____

Relationship to Student: □ Parent □ Guardian □ Other (Please specify)_____

STUDENT RACIAL AND ETHNIC 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.

Name of School:	
School District Student Identification Number:	**Date of Birth (Month/Day/Year):**
Student Name (Last, First, Middle):	**Grade Level:**

DIRECTIONS TO PARENT/GUARDIAN
PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPONS. (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 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 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, NOT OF HISPANIC ORIGIN: A person having origins in any of the black racial groups of Africa.**

☐ **WHITE, NOT OF HISPANIC ORIGIN: A person having origins in any of the original 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 important message to Parents/Guardians and Confidentiality Procedures and Regulations on next page.

STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian:

The Marion Central School District has adopted a policy, which requires the collection and recording of the ethnic identity of students in the Marion Central School in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments
- Plan educational programs and make sure that they are readily available to all students.
- Study the movement of students in different ethnic groups as they move from school to school.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions included in this packet. Put a check (√) in the box for the category or categories which best describes your child. The Marion 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 State and federal student privacy laws and regulations. If the district will be required to identify the group to which the student appears to belong, identifies with, or is regraded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

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

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

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

Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

INTRODUCTION You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district can ask you to provide your consent to access your or your child's public benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. If you choose not to provide your consent, or later decide to withdraw your consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT Beginning on July 3, 2013, before your school district can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time. This consent requirement has two parts. .

1. **Consent to share records about your child:** Your school district is required to obtain your written consent before disclosing [sharing] personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the district will (1) identify the records [or information] about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).
2. **Consent to bill your public insurance program (for example, Medicaid):** Your consent must include a statement specifying that you understand and agree that your school district may use your or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

If your school district has on file your consent that you provided before July 3, 2013 to release your child's records and to use your or your child's public benefits or insurance to pay for special education and related services, your school district is required to request a new consent from you only when there is a change in any of the following: the type of services to be provided to your child (for example, physical therapy or speech therapy), the amount of services to be provided to your child (for example, hours per week lasting for the school year), or the cost of services (that is, the amount charged to the public benefits or insurance program).

If your child is Medicaid eligible, please complete this consent form including your child's CIN number.

If your child is NOT Medicaid eligible, please disregard and initial here._____

Parental Consent to Bill Medicaid

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.
This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district /county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____
(Print Parent's Name) (Print Child's Name)
have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that providing consent will not affect my child's/my Medicaid coverage; upon request, I may review copies of records disclosed pursuant to this authorization, services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid and/or provide my child's CIN. I have the right to withdraw consent at any time; and the school district/county must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/ information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (e.g. records or information about services your child receives, student demographic information):
• **IEP** • **Written Order/Referral** • **Evaluation Reports** • **Session Notes** • **Medication Administration Report** • **Special Transportation Log** • **Other Personally Identifiable Information** • **Any Other Specific Records Pertaining to the Student's Services or Program**

Student's CIN, if known: _____

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____

Print Name _____ Date_____

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

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

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

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

Dear Parent or Person in Parental Relation:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated.

Thank you.

Student Name: _____

First ***Middle*** ***Last***

Date of Birth: _____
Month **Day** **Year**

Gender:
❑ **Male**
❑ **Female**

Parent/Person in Parental Relation Info: _____

Last Name **First Name** **Relation To**

Home Language Questionnaire (HLG)

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?	**Parent 1** ❑ **English** ❑ **Other** ❑ **Specify if other**_____	**Parent 2** ❑ **English** ❑ **Other** ❑ **Specify if other**_____	**Guardian(s)** ❑ **English** ❑ **Other** ❑ **Specify if other**_____
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 Name and 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: ❑ **Parent** ❑ **Other:** _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ **POSITION:** _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ **POSITION:** _____

ORAL INTERVIEW NECESSARY: ❑ **NO** ❑ **YES**

****DATE OF INDIVIDUAL INTERVIEW:** _____ MO DAY YR.	**OUTCOME OF INDIVIDUAL INTERVIEW:** ❑ ADMINISTER NYSITELL ❑ ENGLISH PROFICIENT ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ **POSITION:**

DATE OF NYSITELL ADMINISTRATION: _____ MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

ACCEPTABLE USE POLICY

Internet access is available to students and teachers in the Marion Central School District. Our goal in providing this service to teachers and students is to promote educational excellence in schools by facilitating resource sharing, innovation, and communication.

With access to computers and people all over the world also comes the availability of material that may not be considered to be of educational value in the context of the school setting. On a global network it is impossible to control all materials, and an industrious user may discover controversial information. We (Marion Central School District) firmly believe that the valuable information and interaction available on this worldwide network far outweighs the possibility that users may procure material that is not consistent with the educational goals of the District.

The smooth operation of the network relies upon the proper conduct of the end users who must adhere to strict guidelines. These guidelines are provided here so that users are aware of the responsibilities you are about to acquire. In general, this requires efficient, ethical and legal utilization of the network resources. If a Marion Central School District user violates any of these provisions, his or her access will be terminated. All who use internet access need to read these terms and conditions carefully and understand their significance. Use of Marion technological resources acknowledges compliance with these acceptable use policies.

Computer and internet Terms and Conditions - This policy is intended to establish general guidelines for the acceptable student use of the District's computer system including software, hardware, computer networks, and electronic communications. The same standards of acceptable student conduct which apply to any school activity shall apply to use of the District's computer system. This policy does not attempt to articulate all required and/or acceptable uses of the District's computer systems; nor is it the intention of the policy to define all inappropriate usage. Administrative regulations will further define general guidelines and appropriate student conduct and use as well as proscribed behavior.

Acceptable Use – The use of school computers must support education and research and be consistent with the educational objectives of Marion Central School District. Use of other organization's network or computing resources must comply with the rules appropriate for that network. Transmission of any material in violation of any U.S. or state regulation is prohibited. This includes, but is not limited to copyrighted material, threatening or obscene material, or material protected by trade secret. Use for commercial activities is not acceptable unless explicit prior approval is granted for the purpose of an educational endeavor.

Network Etiquette – Users are expected to abide by the generally accepted rules of network etiquette. These include (but are not limited to) the following:

A. Be polite. Do not get abusive in your messages to others.
B. Use appropriate language. Do not swear, use vulgarities or any other inappropriate language.
C. Hate mail, harassment, discriminatory remarks, and other unacceptable behaviors are prohibited on the network. Therefore, any messages should not contain profanity, obscene comments, sexually explicit material, and expressions of bigotry or hate.
D. All communications and information accessible via the network should not be assumed to be private property.
E. Subscriptions to Listservs or distribution lists must be reported to a system administrator. Prior approval for Listservs is required for students.

Inappropriate Access to Material

A. Users will not utilize the Marion Central School District network to access material that is profane, obscene (pornography), sexually explicit, or that advocates illegal acts, violence or discrimination toward other people (hate literature).
B. If a user mistakenly accesses inappropriate information, they should immediately tell a teacher or other district personnel. This will protect them against a claim of intentional violation of this policy.

Plagiarism and Intellectual Property Infringement

A. Users will not plagiarize works that they find on the internet. Plagiarism is taking the ideas or writings of others and presenting them as one's own original work.
B. Users will respect the rights of copyright and trademark owners. Copyright infringement occurs when one inappropriately reproduces a work that is protected by copyright. If users are unsure whether or not they can use the work, they should request permission from the copyright owner. Direct questions regarding copyright or trademark law to a teacher.

Security

A. Security on any computer system is a high priority, especially when the system involves many users. Routine maintenance and monitoring of the district system may lead to the discovery that you have violated a policy, the school code, or the law. If a violation is suspected it will be investigated fully. While an investigation is underway the user may have their network privileges revoked until the issue is resolved.
B. Users will immediately notify a teacher or the system administrator if they have identified a possible security problem. Do not look for security problems as this may be construed as an illegal attempt to gain access.
C. Note that electronic mail (e-mail) is not guaranteed to be private. People who operate the system do have access to all mail. Messages relating to or in support of illegal activities may be reported to the authorities. Parents have the right at any time to see the contents of their student's network folders or e-mail.
D. The district maintains a networked data storage system that is available to all staff and students. These individuals will be allowed to access and use data storage for any items that pertain to their work or education. If the data storage is used for any other purpose, the privilege may be rescinded at any time deemed necessary.
E. The district maintains a wireless network that is open for staff, students, and community members to use while on school grounds. Any and all data transferred over the wireless network constitutes that the user agrees to any and all applicable rules that govern the wired network and will be enforced as such.
F. Any user identified as a security risk or having a history of problems with other computer systems may be denied access to school computers or the network.

Illegal Activities

A. Network vandalism, such as any malicious attempt to harm, modify, or destroy computer hardware, data of another user, internet bandwidth, or other nefarious intent will result in cancellation of privileges.
B. Users will not attempt to gain unauthorized access to this or any other computer system or go beyond your authorized access by entering another person's account credentials or accessing another person's files. Users shall not intentionally seek information on, obtain copies of, or modify files, other data, or passwords belonging to other users, or misrepresent other users on the network.

Inappropriate Use – MCSD administrators will deem what is inappropriate use and their decision is final. Also, the system administrators may close an e-mail or network account at any time. The administration, faculty, and staff of Marion Central School District may request the system administrator to deny, revoke, or suspend computer use for any reason.

Use of any information obtained via the internet is at your own risk. Marion Central School District specifically denies any responsibility for the accuracy or quality of information obtained through its services.

Appropriate Use of Electronic Devices - Personal technology includes all existing and emerging technology devices that can take photographs, record audio or video, input text, upload and download media, and transmit or receive messages or images. The District shall not be liable for the loss, damage, misuse or theft of any personal technology brought to school. District employees reserve the right to monitor, inspect, and/or confiscate personal technology when there is reasonable suspicion to believe that a violation of district policy or criminal law has occurred.

The use of personal technology in locker rooms, restrooms, Health Office, and any other areas where a person would reasonably expect some degree of personal privacy is prohibited. Students shall not distribute pictures, video, or audio clips of students or staff without their permission.

For specific district provided hardware policy, please see the Marion Chromebook Handbook.

Google Apps for Education - Google Apps for Education (GAFE) is a suite of web-based programs that include a variety of collaboration tools. Student accounts may include tools such as email, shared documents, websites, and blogs. The features and options available will be based on grade level, student awareness and requirements for coursework. Google Apps for Education helps students aspire to their fullest potential and prepare them for tomorrow's opportunities.

Marion CSD will monitor student use of GAFE when students are at school. Parents are responsible for monitoring their child's use of GAFE when accessing programs from home. Students are responsible for their own digital behavior at all times.

Student Use of Email - Electronic mail is a valuable communication tool to increase communication and collaboration and students shall use this tool in a responsible, effective, and respectful manner. Student users may use the District's email system for limited use. Student email use is only for school projects and educational purposes. There is no expectation of privacy in e-mail use. All data files and other electronic storage areas shall be considered to be the property of Marion Central School District to control and inspect for compliance.

Marion Central School District Acceptable Use Policy

It should be understood that all will abide by the above Acceptable Use Policy. It should be further understood that any violation of the regulations above is unethical and may constitute a criminal offense. Should anyone commit any violation, their access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may result.

Signature: _____ **Date**: _____

Chromebook Policy Acceptance Signature Page **Pease Read and Initial For Each Item Below:**	**Student Initial**	**Guardian Initial**
1. I will not loan my Chromebook out to anyone, or leave it unattended unless it is locked in a secure place. My family is responsible for the cost of a replacement should my Chromebook become lost or stolen due to "gross negligence".		
2. I will report any damage immediately to my teacher. In the event of theft or damage by fire I will file a police report within five (5) days of the incident. My family is responsible for the cost of a replacement or repair fees should the administration determine that damage or loss was caused by my vandalism or "gross negligence".		
3. If I'm a Jr-Sr HS Student, I'll charge my Chromebook each night, leave the charger at home, and bring just my Chromebook to school every day. If I'm an Elementary student, I'll charge and store my Chromebook in my teacher's classroom, and only bring it home with my teacher's permission.		
4. I understand that I have no expectation of privacy on the Chromebook and that my use and content is monitored. I also understand that my Chromebook will be filtered and managed at home and at school and I will not try to access inappropriate material.		
5. I have read and understand our School District Code of Conduct and Acceptable Use Policy as approved by our Board of Education and agree to follow them at all times. I will not attempt to go around existing security measures such as internet filters or firewalls.		
6. I agree to be a good digital citizen and not harass, bully, or be insensitive to others when I am online. This includes protecting my identity and passwords and not placing myself or others at risk by sharing personal information online.		
7. I understand that I need to return the Chromebook and power adapter when requested, and that I will receive the same Chromebook back the following school year.		
8. I will do my best to use my Chromebook to enhance my learning and create great things!		

Chromebook Asset #: _____ **Date Issued: _____**

Student Name: _____ **Grade Level: _____**

(Please Print Clearly)

Student Signature: _____ **Date: _____**

Parent/Guardian Name: _____ **Relation to Student: _____**

(Please Print Clearly)

Parent Signature: _____ **Date: _____**

HEALTH INFORMATION

As a part of your child's requirements for school, a **physical examination has been required for new students entering the district** and for students in Prekindergarten or Kindergarten and in **Grades 2, 4, 7 and 10**. Often times it is beneficial for the school nurse to contact your child's health care provider. If you would like to sign the release of information form this could be helpful to obtain necessary health information and avoid delays in care for your child. The health requirements have now been expanded to include the **dental health** of student. A sample certificate is included for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse as it will be filed in your child's Cumulative Health Record.

Before entering school, **children must be satisfactorily immunized**. A copy of the immunization requirements is included in this packet. Please **bring a copy of your child's immunization record with you to registration**. If you do not have a record of your child's immunizations, please contact your health care provider before registration. This information is required to register your child.

The **Health History/Emergency Information** form should be completed and brought to school at registration. The information on this form is very important to assure proper care for your child we need to have your workplace and home/cell telephone numbers. In addition, the names, telephone numbers, email and relationships (grandparents, friends, day care) of other people we may call if you are not available when your child is ill and needs to be taken home from school.

Please do not hesitate to call us with any concerns or questions:

Eliza Weis
Elementary School
(P) 315-926-2431
(F) 315-926-5048

Lauren Penders
JR-SR High School
(P) 315-926-2406
(F) 315-926-2415

Marion Central School District
Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ authorize my child's healthcare provider(s) listed below:

Name_____Phone_____FAX_____

Name_____Phone_____FAX_____

Name_____Phone_____FAX_____

to release the medical records of my child, _____, DOB _____ to the district's:
❒ Medical Director ❒ School Nurse ❒ Athletic Trainer (AT) ❒ Counselor ❒ Occupational Therapist (OT) ❒ Physical Therapist (PT) ❒ Psychologist ❒ Social Worker ❒ Speech Therapist (ST)
❒ other _____

The healthcare provider may disclose the following information: (Parent/School: check all that apply)
❒ Immunizations ❒ Health Appraisals ❒ Past/Current Medical Conditions and impact on attendance, athletics, or school programming or therapy ❒ Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s): (Parent/School: check all that apply)
❒ To develop care or therapy plans for routine and emergent school management
❒ To design appropriate educational, school, or athletic programs
❒ To assess the impact of the medical condition(s) on school programming and/or attendance
❒ To share school observations/concerns surrounding behavior
❒ To assess a medical basis for modification of transportation and/or home tutoring
❒ Medication delivery or therapy prescriptions
❒ At patient's request with no specified purpose
❒ Other_____

PARENT: Please select one.
❒ This authorization is valid for the entire academic school year 20___ - 20_____
❒ This authorization is valid for the duration of attendance within the school district
❒ This authorization shall expire on ____/_____/_____ (MO/DD/YR)

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving 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 and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____

Signature of Parent/Guardian or student if over 18 Relationship Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATIONA SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE ADULT PATIENT OR PARENT OF THE MINOR CHILD

HEALTH HISTORY/EMERGENCY INFORMATION
ALL SECTIONS MUST BE COMPLETED

Child's Name **First, Middle Last:**	**Gender:**
Grade Entering:	
Date of Birth:	**Place of Birth:**
Name of Parent(s)/Guardian Living in Home:	**Address:**
Telephone:	**Cell Phone:**
Name of Parent/Guardian Out of Home:	**Address:**
Telephone:	**Cell Phone:**

List two (2) people with whom you have already made arrangements, who are willing to come to school to get your child in case of illness or accident and will care for them. These people should be persons who would be at home when you are away (designate relations, sitter, friend, grandparent, aunt, etc.).

NAME	RELATION	PHONE
1.		
2.		
Daycare Provider		

FAMILY DOCTOR	TELEPHONE
FAMILY DENTIST	**TELEPHONE**

HEALTH INSURANCE	CONTRACT NUMBER	INSURANCE CARRIED BY

MEDICAL HISTORY

QUESTION	CIRCLE ONE
Does your child have any diagnosed disabilities or diagnosed chronic disease? i.e. Asthma, Diabetes	**Yes No**
If "YES" please explain:	
Does your child have allergies?	**Yes No**
If "YES" please explain what he/she is allergic to, how he/she is treated and by whom:	**Doctor Name**
Does your child have frequent earaches or has he/she had earaches in the past?	**Yes No**
Does your child have any problems with hearing?	**Yes No**
Does your child have any problems with vision?	**Yes No**
Has your child had any communicable disease (i.e. Chicken Pox) or serious illness?	**Yes No**
If "YES" please designate illness, date and doctor who treated your child:	**Doctor Name**
Does your child have any problems with his/her kidneys, bladder or bowels, such as frequent kidney/bladder infections, frequent diarrhea, constipation or bed-wetting?	**Yes No**
If "YES" please explain:	
Has your child had any serious accidents or injuries?	**Yes No**
If "YES" please explain:	
Has your child ever been hospitalized? i.e. surgeries	**Yes No**
If "YES" please state reason for hospitalization, date and doctor who treated your child:	**Doctor Name**
Does your child have seizures or has he/she had seizures in the past?	**Yes No**
If "YES" please describe seizures, frequency, treatment, and doctor who is treating your child:	**Doctor Name**
Is there any family history of seizures?	**Yes No**
Does your child take medication regularly?	**Yes No**
If "YES" what medications, amount and what time of day?	
If your child needs to take medication (prescription or over the counter) during the school day, please contact the School Nurse for a form to be completed by your doctor. Parents must also sign this medication request. The medication will then be dispensed in the Health Office according to the doctor's order.	
When was your child's last physical examination?	
PLEASE ADD ANY INFORMATION THAT WILL HELP US TO MAKE YOUR CHILD'S SCHOOL DAY COMFORTABLE AND SUCCESSFUL:	
Parent/Guardian Signature:	**Date:**

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** ☐ **Non-binary**

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

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 name and address (please print or stamp)	**Dentist'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.**

OPT-OUT/REFUSAL FORM FOR POTASSIUM IODIDE (KI) FORM

Student Name: _____ Date of Birth:_____

Since each of our school buildings are located within the ten-mile emergency planning zone (EPZ) of the Ginna Nuclear Power Plant at 1503 Lake Road, in the Town of Ontario, we are governed by the policy and regulations for distribution of potassium iodide (KI) tablets to the general population within an EPZ zone by the U.S. Nuclear Regulatory Commission (NRC) & State of New York.

KI is an over-the-counter drug that protects the thyroid from exposure to radioactive iodine. It only protects one organ from one radioactive substance. It is not an alternative to evacuation or sheltering.

In the event that evacuation is not immediately possible and/or the state or county Department of Health recommends use of KI, an appropriate dose of KI would be available for your child and coordinated by the school nurse.

If you **DO NOT** wish to have Potassium Iodide (KI) given to your child in the event of a radiological emergency, please indicate if you **DO or DO NOT** object and return it to the school nurse at your child's school within three (3) school days of your child's registration or re-enrollment in the school district.

This form will remain in effect as long as your child is enrolled in the Wayne Central School District or you notify us, in writing that you wish to change the designation by signing and submitting another copy of this form.

OPT-OUT OR REFUSAL NOTIFICATION STATEMENT BY PARENT OR GUARDIAN

" .. I understand that Potassium Iodide (KI) may be given to my child in the event of a radiological emergency if recommend by county emergency officials and/or the NYS Department of Health.

"…. I have read and understand the Questions & Answer Informational Materials from the NYS Department of Health which were provided to me.

"…. I understand that I should direct any questions or concerns, including allergies to seafood, thyroid concerns or any other medical questions to my family physician or health care provider…."

AS THE PARENT/GURADIAN OF THE CHILD NAMED ABOVE, I DO HEREBY STATE THAT:

□ **DO NOT** wish to have Potassium Iodide (KI) given to my child in the event of a radiological emergency

□ **HAVE NO OBJECTION** to having Potassium Iodide (KI) given to my child in the event of a radiological emergency

Name:_____ Signature:_____ Date:_____

Relationship to Student: □ Parent □ Guardian □ Other (Please Specify)

The effectiveness of KI as a specific blocker of thyroid radioiodine uptake is well established. When administered in the recommended dose, KI is effective in reducing the risk of thyroid cancer in individuals or populations at risk for inhalation or ingestion of radioiodine. KI floods the thyroid with non-radioactive iodine and prevents the uptake of the radioactive molecules, which are subsequently excreted in the urine.

2. Can potassium iodide (KI) be used to protect against radiation from bombs other than radioactive iodine, such as radiation from a dirty bomb?
Potassium iodide (KI) works only to prevent the uptake of radioactive iodine into the thyroid gland. It is not a general radio protective agent.

3. Who really needs to take potassium iodide (KI) after a nuclear radiation release?
The FDA guidance prioritizes groups based on age, which is the primary factor for determining risk for radioiodine-induced thyroid cancer. Those at highest risk are infants and children, as well as pregnant and nursing females because of the potential for KI to suppress thyroid function in the developing fetus and the newborn. The recommendation is to treat them at the lowest threshold (with respect to predicted radioactive dose to the thyroid). Anyone over 18 years old and up to 40 years old should be treated at a slightly higher threshold. Finally, anyone over 40 years old should be treated with KI only if the predicted exposure is high enough to destroy the thyroid and induce lifelong hypothyroidism (thyroid deficiency).

4. What potassium iodide (KI) products are currently available?
Only KI products that are FDA-approved may be legally marketed in the United States. As of March 2022, these KI products are FDA-approved and are available without a prescription:

- iOSAT tablets, 130mg, from Anbex, Inc.
- iOSAT tablets, 65mg, from Anbex, Inc.
- ThyroSafe tablets, 65mg, from BTG INTERNATIONAL, Inc.
- Potassium Iodide Oral Solution USP, 65mg/mL, from Mission Pharmacal Company

5. What dosages of potassium iodide (KI) should be taken for specific exposure levels

FDA recommends the following dosing of KI for thyroid blocking following radioactive exposure:

Threshold Thyroid Radioactive Exposures and
Recommended Doses of KI for Different Risk Groups

	Predicted Thyroid gland exposure (cGy)	**KI dose (mg)**	**Number or fraction of 130 mg tablets**	**Number or fraction of 65 mg tablets**	**Milliliters (mL) of oral solution, 65 mg/mL*** **
Adults over 40 years	> 500	130	1	2	2 mL
Adults over 18 through 40 years	> 10	130	1	2	2 mL
Pregnant or Lactating Women	> 5	130	1	2	2 mL
Adolescents, 12 through 18 years*	> 5	65	½	1	1 mL
Children over 3 years through 12 years	> 5	65	½	1	1 mL
Children over 1 month through 3 years	> 5	32	Use KI oral solution**	½	0.5 mL
Infants birth through 1 month	> 5	16	Use KI oral solution**	Use KI oral solution**	0.25 mL

* Adolescents approaching adult size (> 150 lbs or > 70 kg) should receive the full adult dose (130 mg)

** Potassium iodide oral solution is supplied in 1 oz (30 mL) bottles with a dropper marked for 1, 0.5, and 0.25 mL dosing. Each mL contains

65 mg potassium iodide.

*** See the Home Preparation and Dosing Instructions for Making KI Solution using KI Tablets for the Emergency Administration of Potassium Iodide to Infants and Small Children

6. When should I take potassium iodide (KI)?
KI should not be taken as a preventative before radiation exposure. After a radiological or nuclear event in the United States, local public health or emergency management officials will tell the public if there is a need to take KI or other protective actions. After an event in the US, you should follow the instructions given to you by these local authorities. Taking a higher dose of KI, or taking KI more often than recommended, does not offer more protection and can cause severe illness or death.

7. For how long should I take potassium iodide (KI)?
Since KI protects for approximately 24 hours, it should be dosed daily until the risk no longer exists. Priority with regard to evacuation and sheltering should be given to pregnant females and neonates because of the potential for KI to suppress thyroid function in the fetus and neonate. Unless other protective measures are not available, we do not recommend repeat dosing in pregnant females and neonates.

8. Who should not take potassium iodide (KI) or should have restricted use?
Persons with known iodine sensitivity should avoid KI, as should individuals with dermatitis herpetiformis and hypocomplementemic vasculitis, extremely rare conditions associated with an increased risk of iodine hypersensitivity. A seafood or shellfish allergy does not necessarily mean that you are allergic or hypersensitive to iodine. People with nodular thyroid with heart disease should not take KI. Individuals with multinodular goiter, Graves' disease, and autoimmune thyroiditis should be treated with caution -- especially if dosing extends beyond a few days. If you are not sure if you should take KI, consult your health care professional.

9. What are the side effects of potassium iodide (KI)?
Side effects are unlikely when KI is used at the recommended dose and for a short time. The following are possible side effects:

- Skin rashes
- Swelling of the salivary glands
- "Iodism" (metallic taste, burning mouth and throat, sore teeth and gums, symptoms of a head cold, and sometimes upset stomach and diarrhea)
- An allergic reaction can have more serious symptoms. These include fever and joint pains; swelling of parts of the body (face, lips, tongue, throat, hands, or feet); trouble breathing, speaking, or swallowing; wheezing or shortness of breath. Severe shortness of breath requires immediate medical attention.

10. Should I check with my doctor before I take potassium iodide (KI)?
KI is available without a prescription. However, if you have any health concerns or questions, you should check with your doctor before you take KI.

11. As a doctor, should I recommend potassium iodide (KI) for my patients who request it?
As with any drug, physicians should understand the risks and benefits of KI before recommending it or prescribing it to patients. We recommend that physicians read our 2001 guidance https://www.fda.gov/media/72510/download for more information. The FDA guidance discusses the rationale and methods of safe and effective use of KI in radiation emergencies. It specifically addresses threshold predicted thyroid radioiodine exposure for intervention and dosing by age group. The recommendations for intervention are based on categories of risk for thyroid cancer, with the young prioritized because of increased sensitivity to the carcinogenic effects of radioiodine. We also recommend our 2002 guidance https://www.fda.gov/media/72515/download . This guidance provides answers to questions that FDA has received as state and local governments develop emergency response plans involving the use of KI to protect against the effects of radioactive iodine.

12. Should I buy potassium iodide (KI) to keep on hand
KI works best if used within 3-4 hours of exposure. Although FDA has not made specific recommendations for individual purchase or use of KI, the Nuclear Regulatory Commission (NRC) supplies KI tablets, in accordance with FDA dosing guidelines, to states (including tribal governments) that request it for populations within the 10-mile emergency planning zone of a nuclear power plant.
NRC Reference: https://www.nrc.gov/about-nrc/emerg-preparedness/about-emerg-preparedness/potassium-iodide-use.html

13. How do I know that potassium iodide (KI) will be available in case of an emergency
FDA will continue to work with interested pharmaceutical manufacturers to assure that high quality, approved, safe, and effective KI products are available for purchase by consumers, by state and local authorities, and by federal government agencies electing to do so.

CHILD CARE PROVIDER FORM*
For Marion Elementary School Only

DATE: _____

Student Name: _____, _____, _____
(Last) (First) (M.I.)

Child Care Provider's Name: _____

Address of Care Provider: _____

_____

Phone Number of Care Provider: _____

Days at Child Care: (THIS INFORMATION IS FOR TRANSPORTATION PURPOSES)
Please check the days of the week when transportation will be needed to the child care provider.

A.M.	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
P.M.	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
☐ **Not Applicable**					

FIELD TRIP PERMISSION FORM
For Marion Elementary School Only

In order that my child, _____, may receive the educational benefits derived from the attendance on all field trips, I hereby consent to his/her attendance under such conditions as may be prescribed by the school. Some of the tentatively planned field trips are on the school grounds within walking distance (e.g. visits to the bank, post office, Town Park, etc.).

I understand that if the place to be visited is beyond walking distance, student will ride in a school bus driven by an approved bus driver.

Further, I understand that field trip descriptions, which will include location, time and other specific information, will be sent home prior to each trip.

My signature below authorizes my child to participate in all walking and bused field trips.

Signature: _____ Date: _____

FOR TRANSPORTATION USE
Copied Date: _____
☐ **Entered Traversa**
☐ **Entered SchoolTool**
☐ **Driver's Route**

Student Transportation Request Form 2024 – 2025
This application must be returned no later than **August 20, 2024**
To:
Marion Central School District
Transportation Department
4048 Park Dr., Marion, NY 14505
slochner@marioncs.org / tcollie@marioncs.org
(315)-926-2436

SCHOOL: _____ GRADE:_____

STUDENT'S NAME: _____ _____ _____
LAST Name FIRST Name Date of Birth

Parent/Guardian: _____
Father's Name & Mother's Name (include both if applicable) OR Guardian Name

_____ _____ _____
Home Phone # Mother/Guardian Cell Phone Father/Guardian Cell Phone

Please Include Area Code

_____ _____
Mother/Guardian Work Phone Father/Guardian Work Phone

_____
House Number/Street Name

_____ _____ _____
Town State Zip Code

Please fill in the boxed below to indicate where your child will be picked up and dropped off: This must remain consistent throughout the remainder of the school year.

The pickup and drop off point:

Only one alternate address with a permanent schedule will be allowed.

	Home	**Day Care**	**Day Care Provider Name**	**Address**	**Home Phone #**	**Cell #**	**Permission to pickup**
Mon thru Fri							

If any of the above information changes during the school year, a new form must be completed. Forms can be picked up and dropped off at the school offices and/or via email. Please allow five (5) days for changes to become effective.

I hereby authorize the Marion Central School District to transport my child to/from the locations listed above.

_____ _____
Date Signature of Parent/Guardian

PLEASE NOTE: Forms MUST be submitted to Transportation Department every school year!

MARION CENTRAL SCHOOL DISTRICT
4034 Warner Road
Marion, NY 14505
District Office: 315-926-2300 Fax: 315-926-5797

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Name of Student: _____ DOB: _____ Last Enrolled Grade: _____

Previous District: _____ School Name: _____

School Address: _____

School Phone#_____ Fax#_____

Please release the records available listed below to the building noted below- Thank you!

- □ **Report Card(s); Grades K-6 ***
- □ **Transcript(s) Grades 7-12***
- □ **Academic Records ***
- □ **State Test/Standardized Test***
- □ **Signed Custody/Guardianship**
- □ **Attendance Records**
- □ **Current IEP/504 Plan***
- □ **Special Education Evaluations**
- □ **Health Record/Physical Exam**
- □ **Immunization Record**
- □ **Dental Health Certificate**
- □ **Proof of Age**

(*)Required in order to determine class placement or schedule of courses prior to registration/re-enrollment
** If Student has an IEP please include most recent Psychological Reports, Educational Reports, Speech Evaluations, Physical Therapy Evaluations, Occupational Therapy Evaluations and any other pertinent evaluations and reports**

PARENTAL PERMISSION: I hereby authorize school records to be released to:

Marion Central School District Office:
Attn: Sandy Friday
4034 Warner Road
Marion, NY 14505
Phone: 315-926-2300 EXT 1205
Fax: 315-926-5797

Signature: _____ Date**:** _____

□ Parent/Guardian □ Student/Self □ School Official – Title: _____