Charter School of Inquiry
404 Edison St. Buffalo, NY 14215
Phone: 833-3250 Fax: 831-7947

1. STUDENT REGISTRATION FORM

STUDENT DATA

Print Name: (First/ Middle/ Last)		Birth Date:
Grade Level:	Gender: Male/Female	Age Today:
Student's Legal Residence: (Street address)		
City/State/Zip	Primary Phone:	
	Secondary Phone:	

MAILING ADDRESS (complete only if different from student's legal residence noted above)

Mailing Address:			
City	State:	Zip:	Home Phone:
			Secondary Phone:

CHILD CUSTODIAL INFORMATION

Who has custody of the student currently? (Circle)
Both Parents Mother Father Guardian Other:_____

With whom does the student live? (Circle)
Both Parents Mother Father Guardian Other:_____

I certify that I have legal custody of _____
Please submit a copy of current custody papers to the school office.
Student Name (Print)

Signature:	**Date:**

FIRST PARENTAL/GUARDIAN CONTACT *(PLEASE PRINT):*

Name: (First/Last)	Employer:		
Relationship to Student:	Work Phone:		
Address:	City:	State:	Zip:
Preferred method of contact: cell email home phone	Cell:	Home:	
Email:			

SECOND PARENTAL/GUARDIAN CONTACT *(PLEASE PRINT):*

Name: (First/Last)	Employer:		
Relationship to Student:	Work Phone:		
Address:	City:	State:	Zip:
Preferred method of contact: cell email home phone	Cell:	Home:	
Email:	Authorized to pick up child from school? ☐Yes ☐ No		

FIRST EMERGENCY CONTACT *(PLEASE PRINT):*

Name: (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Email:	Authorized to pick up child from school? ☐Yes ☐ No

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SECOND EMERGENCY CONTACT *(PLEASE PRINT):*	
Name: (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Email:	Authorized to pick up child from school? ☐Yes ☐ No

Additional Individuals Authorized to Pick up Student from School	
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No
Name:	Relationship to student:
Phone number:	Authorized to pick up child from school? ☐Yes ☐ No

Please note that a child will only be released to an adult who is listed on official school forms as authorized for pick up.

Parent/Guardian Signature **Parent/Guardian Printed Name** **Date**

Family Sibling(s) Name (First/Last)	Age	Gender	Current Grade	School Attending	Lives with Student?
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N
		M or F			Y or N

CERTIFICATION

I hereby certify that the student listed on this registration form actually resides at the address specified on page 1.
I further certify that all the information I provided on this form is true and correct. I understand that I must immediately notify the Charter School of Inquiry if the residency of the student changes from the address listed.

Parent/Guardian Signature **Parent/Guardian Name Printed** **Date**

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2. STUDENT'S BIRTH CERTIFICATE OR PASSPORT

Parent/Guardian,

Please **attach a copy of your child's birth certificate or the information page from your child's passport** which clearly the date of birth of your child. You may bring the document to the school at 404 Edison St., Buffalo, NY 14215 to be photocopied for the child's school file if you do not have access to a copier.

For CSI Office Use		
Type of Document (attached)	**Name of Staff Verifying Document**	**Date**

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3. Student Racial and Ethnic Identification

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

DIRECTIONS TO PARENTS/GUARDIANS

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check **(√)** the box that best describes your child.] Check only **(√)** ONE box.

1. **Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

2. **Select one or more races from the following five racial groups** [For question (2) Check ( ) all groups that apply to your child; check 9) 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 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**: A person having origins in any of the black racial groups of Africa

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

Relation to Student (please check one box below)

_____ _____

Signature of Parent/ Guardian/ Date

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4. RESIDENCY VERIFICATION FORM AND CHECKLIST

NAME OF STUDENT: _____

Name of Person Establishing Residency: _____

I AM THE (CHECK ONE): ____Parent ____ Legal Guardian ____ Foster Parent

____Relative Caregiver ____ Other: (specify) _____

CONFIDENTIAL INFORMATION

COMPLETE THIS BOX IF IT REFLECTS YOUR CHILD'S CURRENT LIVING SITUATION. Your answer will assist school staff with school enrollment and may enable the student to receive additional services under the McKinney –Vento Homeless Act.

CHECK ONE BOX IF YOU ARE LIVING:

- □ with relatives or others **due to lack of housing**
- □ in a motel/hotel, camp ground, or other similar situation **due to lack of adequate housing**
- □ in a shelter
- □ at a train or bus station, park, or in a car
- □ in an abandoned apartment/building

***IF NONE OF THESE SITUATIONS APPLY TO YOU, PLEASE CONTINUE WITH THE RESIDENCY INFORMATION REQUESTED BELOW.**

RESIDENCE:

I affirm that the student(s) resides at the following street address:

Street Address: _____ Apartment Number/Unit_____

City: _____ State:_____ Zip Code:_____

FALSIFICATION OF ANY INFORMATION OR DOCUMENTS, EITHER WRITTEN OR VERBAL RELATIVE TO THIS VERIFICATION PROCEDURE WILL RESULT IN REVOCATION OF ENROLLMENT.

SIGNATURE OF PERSON ESTABLISHING RESIDENCY: _____ **DATE:** _____

The person establishing residency must return this form with copies of any two of the following documents:

- □ Deed to Home
- □ Rental Agreement/Rental Receipt
- □ Bank Statement
- □ Mortgage Payment Receipts or Coupons
- □ Property Tax Receipt
- □ Driver's License (with matching address)
- □ Bill from Local Utility Company, Cable TV, etc.
- □ Military Orders (Base Housing)
- □ Declaration of Temporary Residency Affidavits for Homeless Families
- □ Any Other Legal Document which Establishes Home Address: _____

The document(s) described as checked above was presented by the person identified above, establishing residency for the student(s) listed above. The student's registration address matches the address on the residency verification documentation.

Signature of CSI staff verifying residency: _____

Date: _____

on 2018-2019

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5. LANGUAGE QUESTIONNAIRE (HLQ)

ALL FORMS MUST BE COMPLETE AND RETURNED TO CSI BEFORE A STUDENT TTENDS SCHOOL

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 English. Your assistance in answering these questions is greatly appreciated. Thank You.

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** _____
specify

2. What language(s) are spoken most of the time to the student in the home or residence? ❑ **English** ❑ **Other** _____
specify

3. What language(s) does the student understand? ❑ **English** ❑ **Other**_____
specify

4. What language(s) does the student speak? ❑ **English** ❑ **Other** _____
Specify

5. What language(s) does the student read? ❑ **English** ❑ **Other** _____ ❑ **Does Not Read**
specify

6. What language(s) does the student write? ❑ **English** ❑ **Other** _____ **Does Not Write**
specify

7. In your opinion, how well does the student **understand, speak, read and write English? (Check one box per row.)**

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

_____ _____
Signature of Parent/Guardian **Date**

For CSI Office Use Only	
Determination: ❑ Possible LEP ❑ English Proficient	
Signature of School Personnel:	Date:

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6. BUFFALO PUBLIC SCHOOLS YELLOW BUS TRANSPORTATION FORM (2018-2019 SCHOOL YEAR)

BUS TRANSPORTATION

Are you requesting bus transportation for your child(ren)?: (Circle one) : Yes No

BPS transportation form is attached and should be completed and returned to the school. Please press down hard when completing the form to go through all carbon copies. CSI will submit all completed requests to BPS Transportation Department. If your child is eligible for yellow bus transportation, you will receive a letter directly from BPS. If you are not eligible (living within the .7 mile walking zone for the Charter School of Inquiry), CSI will notify you by letter before school starts.

If you are not using bus transportation, please acknowledge that your child(ren) will be dropped off and picked up from CSI at the school's arrival and dismissal times:

Parent/Guardian Signature: _____

Please Note: Children eligible for busing will be picked up in the morning and will be taken home at the regular dismissal time of 3:15 pm. If you choose to have your child stay for the extended day program (from 3:30 pm to 5:30 pm), you must pick her or him up at school **BEFORE** 5:30 pm as there is no bus transportation after the extended day program.

FOR CSI OFFICE USE ONLY

Date Bus Transportation Requested and faxed to Transportation Dept.: _____
Additional Transportation Notes:

Staff Signature _____

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7. AUTHORIZATION AND REQUEST FOR PERMANENT SCHOOL RECORDS FOR STUDENTS ENTERING GRADES 1-5

Charter School of Inquiry has enrolled the following student: _____for the coming school year. It is requested that a copy of the school records be released or transferred to the Charter School of Inquiry.

TO BE COMPLETED BY PARENT OR GUARDIAN			
Name of school your child last attended (18-19 school year):			
School Address:			
City:	*State:*	*Zip:*	*School Phone:*
			Fax number:
Last Grade Attended:			*Date of Birth:*
Other Schools Attended:			

AUTHORIZATION

Parent/Guardian: _____
Print name

Parent/Guardian: _____
Signature

Relationship to Student: _____ Date: _____

TO FORMER SCHOOL: Please include any of the following that may apply to this child. Thank you for your cooperation.

Student Record (√ if included)	*Student Record (√ if included)*
☐ **Cumulative Records**	☐ **Student 900 number or other ID**
☐ **Attendance Records**	☐ **Special Education (IEP)/MFE/ETR/504 Plan**
☐ **Copy of Student's Data Form**	☐ **Expulsion/Suspension Documents**
☐ **Grade Card (or information about pupil placement)**	☐ **Immunization Record(s)**
☐ **Dental Record(s)**	☐ **Copy of Birth Certificate**
☐ **Medical Record(s)**	☐ **Custody/Court Documents**
☐ **Social Security Card**	☐ **Proof of Residency**
☐ **Intervention Team Records/Data (AIS)**	☐ **ELL language and service plan**
☐ **Title 1/DIBELS Data and Records**	☐ **Other: specify_____**

Please send all student records to CSI:

Via Mail:
Charter School of Inquiry (CSI)
404 Edison St.
Buffalo NY 14215

Via Fax:

716- 831- 7947
Attention: Courtney Eaton

Charter School of Inquiry
404 Edison St. Buffalo, NY 14215
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8. CONSENT FOR MEDICAL TREATMENT

(SMR1)

I, as the parent/guardian of _____ give Charter School of Inquiry permission to provide routine medical assistance by health professionals in school and to seek appropriate medical attention for my child in the event of an accident or health related incident.

Parent/Guardian Signature: _____ **Date:** _____

INSURANCE INFORMATION	
Insurance Provider:	Member ID Number:
Primary Physician:	Telephone Number:

List all medications taken, if applicable (at home and at school)

If your child has a health condition, please check any of the following that may apply and explain:

- ☐ Allergies: specify _____
- ☐ Bee Stings
- ☐ Swelling problems
- ☐ Breathing difficulty (Name of medication needed and dose)
- ☐ Other: _____

☐ Asthma Inhaler needed: Yes ☐ No ☐

☐ Convulsions or seizures

☐ Diabetes

☐ Heart condition

☐ Hearing problem Tubes in ears

☐ Speech problem

☐ Vision problem

☐ Wears glasses or contact lenses

☐ Any condition that might prevent your child from participating in P.E?

☐ Other health concerns

Does your child receive any of the following services:

- ☐ Special education (with an IEP)
- ☐ 504 Review services
- ☐ ESL services
- ☐ Other - specify_____

If yes, explain: _____

_____

_____

_____

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9. PHYSICIAN MEDICAL RECORDS AND IMMUNIZATIONS (SMR2)

Medical records must be on file before student attends school.

STUDENT NAME_____ **Date:** _____

SCREENINGS (to be completed by nurse or physician)

Height: _____ (%)	Weight: _____ (%)	Blood Pressure: _____ (%)

VISION	HEARING	SPEECH & LANGUAGE
Distance Acuity R_____ L_____	Audiometric Thresholds:	Speech Assessment: Yes No
Muscle Balance: Pass Fail N/A	Right Ear: Pass Fail N/A	Child has possible problem with:
Farsightedness: Pass Fail N/A	Left Ear: Pass Fail N/A	Voice: Yes No
Color: Pass Fail N/A	Other Tests (specify):	Articulation: Yes No
Child wears glasses? Yes No	Child wears hearing aid? Yes No	
Tested with glasses? Yes No	Tested with hearing aid? Yes No	
Referral made? Yes No	Referral made? Yes No	

EXAMINATIONS (to be completed by nurse or physician)

Head _____	Mouth_____	Genitalia_____	Lungs_____
Neck_____	Teeth_____	General Condition_____	Hernia_____
Nose_____	Abdomen_____	Orthopedic_____	Urinalysis_____
Throat_____	Heart_____	Nervous System_____	

PHYSICIAN REMARKS & RECOMMENDATIONS

Physician Remarks & Recommendations:

This child is authorized to participate fully in:

- Classroom & academic activities Yes No
- Physical education classes Yes No

Specify any limitations

Physician Signature:

_____

Date:

_____

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10. RECORD OF IMMUNIZATIONS (SMR3)

All children between the ages of 2 and 18 years old must show proof of compliance with immunization requirements of Public Health Law Section 2164. The chart below summarizes the immunization requirements for school entrance/attendance from the NYS Department of Health.

Student Name: _____ **Birthdate:** _____ **Grade entering** _____

Parent/Guardian: This form is to be completed by your child's physician. The doctor may choose to attach a copy of your child's immunization history to this form **OR enter the MONTH, DAY, and YEAR for all vaccines your child received.** A child's immunization history must include all of the following vaccines to be considered fully immunized. Their immunization record should be evaluated according to the grade they are attending this school year.

Type of Vaccine	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) • for children age 6 years and younger • final dose on or after age 4 years					5th dose not required if 4th dose was given on or after the 4th birthday
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade					
Polio (IPV, OPV) • final dose on or after age 4 years For children 4 years of age or older who have received less than 3 doses, a total of 3 doses are required. If both OPV and IPV were administered as part of a series, a total of 4 doses should be received, regardless of the child's current age.					If 4 or more doses were administered before age 4 years, an additional dose should be received on or after age 4 yrs.
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday					
Hepatitis B (hep B)					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required					

Note to Parents: The above schedule is the requirement for students who begin receiving their vaccines in infancy. There are different requirements for students who begin their vaccinations at a later age. If you have questions, please consult with your physician.

1. Demonstrated serologic evidence of measles, mumps, rubella, hepatitis B, varicella or polio (for all three serotypes) antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Immunization requirements updated as of April 2014. Please refer to http://www.health.ny.gov/prevention/immunization/schools/ for updated information and Frequently Asked Questions (FAQs).

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11. EXEMPTION TO STATE IMMUNIZATION LAW (SMR4)

Parents/Guardians

There are two exemptions that can be recognized for exemption to State Public Health Law *Section 2164.*

1. **Medical Exemption**: If the student's physician believes the immunizations are medically inadvisable for reason of medical contraindication, history of disease, or laboratory evidence of immunity, a written statement to that affect signed by the physician must be given to the school each school year. In the case of varicella disease, only history of the disease which was medically diagnosed will be accepted.

2. **Religious Exemption**: If you have a religious objection to immunizations, you, the parent must write a statement to the Head of School indicating your religious objections. You must provide such a letter each year your child is in school.

Please be aware that students who have a waiver of immunization either for medical or religious reasons will be excluded from school if there is an outbreak of a disease for which the student is not immunized.

I have read the requirements for immunization of my child for entry and attendance at school and agree to comply with New York State Public Health Law as explained above.

Parent Signature: _____ **Date:** _____

For Office Use Only	
Type of Exemption requested	
☐ Medical	Statement received: Physician's Name_____ Date: _____
☐ Religious	Parent Statement Received on: Date:

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12. STUDENT DENTAL REPORT (SMR5)

Parent/Guardian: This form should be given to your child's dentist to complete and return to you.

STUDENT DATA		
Last Name:	First Name:	MI:
Gender (circle): Male / Female	Birthdate:	

DENTIST INFORMATION			
Dentist Name:	Phone:	Fax:	
Address:	City:	State:	Zip:
Signature:	Date:		

The following SERVICES were performed:			The following ORAL HYGIENE instruction was provided:		
Examination	Yes	No	How to brush effectively	Yes	No
Diagnosis	Yes	No	How to floss	Yes	No
Radiographs	Yes	No	Dental health nutrition counseling	Yes	No
Oral Prophylaxis	Yes	No	How to use fluoride mouth rinse	Yes	No
Prescription for Fluoride Supplements	Yes	No			
Topical Application of Fluoride	Yes	No			

DENTIST'S COMMENTS

Dentist's Signature: _____ Date: _____

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13. MEDICATION GUIDELINES FORM FOR IN-SCHOOL ADMINISTRATION (SMR 6)

The New York State Education Law states that for medication to be administered to a student by school personnel, the following regulations must be followed:

1. **A written statement from the student's health care provider** indicating the frequency, dosage, route of administration, duration and possible side effects of the medication must be provided.
2. **A written statement from the parent** requesting that school personnel give the medication.
3. **Medication must be brought to school by the parent**. The medication ***cannot*** be brought in by the student.

NOTE: The above guidelines refer to all prescription medications and all over-the-counter medications. (Tylenol, medication for menstrual cramps, cough drops, Neosporin ointment, etc.) *If a child is to be allowed to carry his/her own medication in school (i.e. inhaler for asthma) that must be specifically stated.*

Last Name: _____ First Name: _____ MI: ___ Birth Date: _____

Student Address: _____

City: _____ State: ____ Zip: _____ Home Phone: _____

Name of prescribed medication:_____ Dosage: _____

Number of times/intervals medication is to be administered: _____

Dates administration to begin and end: _____

Adverse or severe reaction that should be reported to physician: _____

Special instructions for administration of medication: _____

The medication can be safely administered by non-medical personnel: Yes No

_____ _____
Physician's Name Phone Number

_____ _____
Physician's Signature Date

_____ _____
Parent's Name Parent's Phone Number

_____ _____
Parent's Signature Date

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14. Publicity Release Permission Form

2017-2018 School Year

Throughout the school year there will be numerous occasions when we will be publishing news about our students. We will also take pictures throughout the school year to use on our website, Facebook page, family communicator and yearbook. We may also contact local media outlets (newspapers, television stations, radio stations, etc.) for informational and educational purposes regarding the programs or curriculum at Charter School of Inquiry.

PLEASE CHOOSE ONLY ONE OPTION BELOW:

I, _____(parent/guardian), ***give*** Charter School of Inquiry permission to use my child's picture and/or name for publicity purposes.

OR

I, _____(parent/guardian), ***do not give*** Charter School of Inquiry permission to use my child's picture and/or name for publicity purposes.
It should be understood that by selecting this option the school will not be permitted to use your child's picture and/or name for any publication purposes including the school yearbook or via the media outlets stated above.

(**Print please**)

Student's Name _____ Grade_____

Student's Name _____ Grade_____

Student's Name _____ Grade_____

Parent/Guardian's Signature _____ Date _____

An unreturned Publicity Release Permission Form will be considered as permission **not** given.
A parent or guardian may make a change to the Publicity Release Permission Form by submitting a Publicity Release Permission Revocation Form, available in the school office.

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15. Family Income Range Form

Dear Parent/Guardian:

Charter School of Inquiry participates in the Community Eligibility Provision (CEP) under the National School Lunch Program. Under CEP all students receive a breakfast/lunch at no charge for the entire school year. We do not request that you complete an application for free or reduced lunch based on income eligibility. We now are asking parents/guardians to complete a confidential household income form to determine eligibility to receive additional benefits for your child(ren).

Many state and federal programs use socioeconomic status (that is, household and income information) to determine eligibility for their programs. In addition, the primary state funding calculation uses socioeconomic status. By completing this form our school is able to determine eligibility for additional programs your child(ren) may qualify for. *Regardless, your child(ren) will still receive meals at no charge at school.*

You must include all people living in your household, related or not (such as grandparents, other relatives, or friends) who share income and expenses. You must include yourself and all children living with you.
The information received is combined for all students at CSI to help our school qualify for federal Title I & II funds to support literacy and math instruction, assess educational progress, and decide eligibility for supplemental state and local nutrition programs.

Please use the chart below to determine your household income. Once you identify your level, please check the appropriate response category below. Thank you.

Federal Guidelines for Free/Reduced Lunch Program: PLEASE CIRCLE # IN HOUSEHOLD & INCOME LEVE THAT BEST PERTAINS TO YOUR HOUSEHOLD. Thank you.

CHECK ONE

# of people in household	1	2	3	4	5	6	7	8	Each additional person add

CHECK ONE

Annual household income less than	$21,775	$29,471	$37,167	$44,863	$52,559	$60,255	$67,951	$75,647	$7,696

Family Income – Per the above guidelines, do you believe your child would be eligible for the Federal Free or Reduced Price Lunch Program? YES_____ NO_____ SNAP or TANF (if applicable) #: _____

Parent/Guardian Name (Please Print): _____ Date:_____

Parent/Guardian Signature: _____