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

1. RE-ENROLLMENT FORM: 2018-2019

All students currently enrolled at CSI will be guaranteed a seat in the upcoming 2018-2019 school year. Please complete the below information so that we can reserve a seat for your child.

PLEASE PRINT

Parent/Guardian Name ____

Address ______________________ **City** _________________ **State** _________ **Zip** ________

Phone (H) _______________ **Cell** ___________ **Email** _______________________________

Parent/Guardian Name ____

Address ______________________ **City** _________________ **State** _________ **Zip** ________

Phone (H) _______________ **Cell** ___________ **Email** _______________________________

School District of residence ____

With whom does the child (ren) reside? ______________________________

Who has legal custody? ____________________________ **(please submit court papers)**

List the names of your children **who already** attend Charter School of Inquiry **and** will do so next year:

Name	**Grade Level in 2018-2019**
______________________________	__________________
______________________________	__________________
______________________________	__________________
______________________________	__________________

Is there **a sibling** of a current child that will be applying to the Charter School of Inquiry for 18-19?

□**YES** □**NO**

If yes, name: ____ Grade: ___________

► ________ Our family **will not** be returning to Charter School on Inquiry for the 2018-2019 school year.

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First Emergency Contact (Please Print)	
Name (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Address:	Work Phone:
City/State/Zip	Authorize to pick up child from school? Yes □ No □
Second Emergency Contact (Please Print)	
Name (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Address:	Work Phone:
City/State/Zip	Authorize to pick up child from school? Yes □ No □
Third Emergency Contact (Please Print)	
Name (First/Last)	Home Phone:
Relationship to Student:	Cell Phone:
Address:	Work Phone:
City/State/Zip	Email
City/State/Zip	Authorize to pick up child from school? Yes □ No □

Additional Individuals Authorized to pick up Student from School	
Name:	Relationship to student:
Name:	Relationship to student:
Name:	Relationship to student:

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

Parent Signature	**Parent Name (Print)**	**Date**

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3. Residency Verification form and Checklist

Name of Student: ____

Name of person Establishing Residency: ____

I AM THE (CHECK ONE): ______ Parent ______Legal Guardian ______Foster Parent

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.

RESIDENCY

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 **2** 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 with 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 on the residency verification documentation.

Signature of CSI staff verifying residency: ____

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4. 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**	
Student Name (Last, First, Middle):	
Date of Birth (Month, Day, Year):	**Garde 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; MUST 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 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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5. CONSENT FOR MEDICAL TREATMENT (SMR 1)

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 medical attention for my child in the event of an accident or health related incident.

Parent 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 off the following services?

Special Education (with an IEP)
504 Review services
ESL services
Other (specify)

____
____
____
____

If medication is to be administered at school, Form # 10, **Medication Guidelines for In School Administration, must be completed.

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6. PHYSICAL MEDICAL RECORDS AND IMMUNIZATIONS (SMR 2)

Students 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:	Voice: Yes No
Color: Pass Fail N/A	Other Test (specify)	Articulation: Yes No
Child wears glasses? Yes No	Child wears hearing aid? Yes No	
Tested with glasses? Yes No	Tested with hearing? Yes No	
Referral made? Yes No	Referral made? Yes No	

EXAMINATIONS (to be completed by nurse or physician)		
Head_________________	Mouth ___________________	Genitalia _______________________
Neck _________________	Teeth ____________________	Orthopedic _____________________
Nose _________________	Abdomen _________________	Nervous System _________________
Throat ________________	Heart _____________________	Urinalysis _______________________
Lungs _________________	Hernia ____________________	General Condition _________________

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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7. 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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8. 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: Date:

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9. 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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10. MEDICATION GUIDESLINES 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: _________________________ DOB: ____________

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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11. 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.

2/26/2018

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12. 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 CHECK THE # OF PEOPLE 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: _________________________________