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

1. RE-ENROLLMENT FORM: 2020-2021

All students currently enrolled at CSI will be guaranteed a seat in the upcoming 2020-2021 school year. Please complete the below information so that we can reserve a seat for your child.

PLEASE PRINT

1. **Parent/Guardian Name** ______________________________

Address ____________ **City** __________ **State** _______ **Zip** _______

Phone (H) __________ **Cell** ________ **Email** ________________

2. **Parent/Guardian Name** ______________________________

Address ____________ **City** __________ **State** _______ **Zip** _______

Phone (H) __________ **Cell** ________ **Email** ________________

School District of residence: □Buffalo □Cheektowaga □Cheektowaga/Maryvale □Kenmore □ Amherst □Other ____________________

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 2020-2021**
1. ______________________	______________
2. ______________________	______________
3. ______________________	______________
4. ______________________	______________

Is there **a sibling** of a current child that will be applying to the Charter School of Inquiry for 20-21?
□YES **□NO**

If yes, name: ______________________________ Grade: __________

► ________ Our family **will not** be returning to Charter School on Inquiry for the 2020-2021 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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2. 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, campgrounds, 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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3. Publicity Release Permission Form
2020-2021 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_____

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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4. 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 LEVEL 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	**UNDER** $21,775	**UNDER** $29,471	**UNDER** $37,167	**UNDER** $44,863	**UNDER** $52,559	**UNDER** $60,255	**UNDER** $67,951	**UNDER** $75,647	**ADD $(+) 7,696**

SNAP or TANF # (***if applicable***): ____

Student's Name ____ Grade_____

Student's Name ____ Grade_____

Student's Name ____ Grade_____

Student's Name ____ Grade _____

Parent/Guardian Name (Please Print): ______________________________________ Date: _______________

Parent/Guardian Signature: ____

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5. FIELD TRIP PERMISSION FORM
2020-2021

Your child will have the opportunity to participate in planned school field trips. You will be informed in advance about upcoming field trips. Some field trips may require a small fee. You will also be informed about the fee in advance. Please sign below to permit your child to attend the field trips that will be planned. By signing below, you will also give medical consent to treat your child if necessary. This permission form will be kept at the school and will be active for the entire school year. **YOU WILL NOT BE REQUIRED TO COMPLETE ANOTHER PERMISSION FORM**. Please also note that you will need to complete one form for *every* child enrolled in Charter school of Inquiry

I GIVE PERMISSION FOR MY CHILD(REN)TO ATTEND THE FIELD TRIP.

Student's Name ____ Grade_____

Student's Name ____ Grade_____

Student's Name ____ Grade_____

Student's Name ____ Grade _____

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND AGREED TO THE ABOVE AND THAT WE HAVE YOUR PERMISSION TO TAKE YOUR CHILD(REN) ON THIS FIELD EXPERIENCE.

Parent Name (Print): ____

Parent/ Guardian Signature:____

Address: ____

Home Phone:____________________ **Work Phone:** __________________________

Person to contact in an Emergency: ____

Emergency Phone #: ____

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6. Medical Health History Form

Student Name: _____________________________________ Grade: _______________

Has your child ever had any of the following conditions? (Please check YES to those that apply)

Condition	YES	Condition	YES
Allergies		Chicken Pox	
Asthma		Hepatitis	
Pneumonia/Bronchitis		Rheumatic Fever	
Head Injury/Concussions		Tuberculosis	
Seizures		Diabetes	
Spinal Injury		Speech Problems	
Hearing Problems/Deafness		Skin Conditions	
Vision Problems		Testicles: Injury/Surgery/Hernia	
Cystic Fibrosis		Surgery	
Cerebral Palsy		Heart Condition	
Dental Problems		Lead Poisoning	
Vision Problems/Glasses		Muscle Problems	
ADD/ADHD		Sickle Cell Disease	
Behavioral Problems		Frequent Urination/Wetting	
Emotional Problems		Bleeding Problems	
Speech Problems		Bowel Problems	

If you answered YES to ALLERGIES, please list them below & explain the necessary procedure if a reaction were to occur:

____
____
____

If you answered YES to ANY OTHER CONDITION, please explain below:

____
____
____
____

Please describe any other important health-related information about your child that we should be aware of:

____
____
____
____

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7. First Aid and Emergency Release

I authorize the Charter School of Inquiry school staff members who are trained in the basics of first aid and CPR to administer first aid and/or CPR to my child when appropriate and necessary.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. In the event of an emergency requiring medical attention for my child, if I cannot be reached or if the school determines that delay would be dangerous to my child's health, I hereby authorize the school's staff members to secure the necessary medical treatment for my child.

Student Name: ____ **Grade**: ________

Student Name: ____ **Grade**: ________

Student Name: ____ **Grade**: ________

Student Name: ____ **Grade**: ________

The above emergency and medical information and release is provided by:

Parent/Guardian Name (PRINT): ____

Parent/Guardian Signature: ____

Date: ___________

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8. New York State Immunization Requirements

The shaded boxes indicate that these doses are not routinely given. However, if your child has received them, please write the date in the shaded box.

Attention Parent/Guardian: **THIS FORM IS TO BE FILLED OUT BY YOUR CHILD'S PHYSICIAN**. They 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 has received**. A child's immunization history must include all of the following vaccines to be considered fully immunized and be in compliance with NYS requirements.

Type of Vaccine	1st Dose (Mo/Day/Year)	2nd Dose (Mo/Day/Year)	3rd Dose (Mo/Day/Year)	4th Dose (Mo/Day/Year)	5th Dose (Mo/Day/Year)
Diptheria, Tetanus & Pertussis (DTaP, DTAP, DT) • For children age 6 years and younger • Final dose on or after age 4 years					(5th dose not required if 4th dose given on or after the 4th birthday)
Tetanus and Diptheria (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					
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 administrated as part of a series, a total of 4 doses should be received, regardless of the child's current age)					
Measles, Mumps, and Rubella (MMR) • Minimum age: On or after 1st birthday					
Hepatitis B (HepB)					
Varicella (Chicken Pox) • Minimum age: on or after 1st birthday • Vaccine or disease history required.					

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9. Exemption to State Immunization Law

Student's Name ____ Grade_____

Student's Name ____ Grade_____

Student's Name ____ Grade_____

Student's Name ____ Grade _____

There is only **one exemption** that can be recognized by NYS 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/primary care physician must be given to the school each school year.

Please be aware that students who have a waiver of immunization will be excluded from school in the event of an outbreak of a disease for which the student is not immunized.

I have read the requirements for immunizations of my child for entry & attendance at school (listed on the previous page) and agree to comply with New York State Public Health Law as explained above.

Parent/Guardian Signature: ________________________________ Date: _______________

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10. PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Name of student:____**DOB:**________________

Diagnosis:____

A. To be completed by physician:
I request that my patient, as listed above, receive the following medication:

MEDICATION	DOSAGE	FREQUENCY/ TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

DURATION OF TREATMENT: 2019/2020 school year (including any summer sessions) Other ______________________

Please note: Medications and treatments will not be administered on early release days, with the exception of emergency medications, procedures and treatments.

Possible Side Effects and Adverse Reactions (if any): ____

PLEASE CHECK ONE:

______ I deem this child to be **NON SELF –DIRECTED** and understand that administration of oral, topical, inhalant, and injectable medication must remain the responsibility of the school nurse, licensed practical nurse under the direction of the school nurse, physician or parent.

______ I deem this child to be **SELF-DIRECTED** and understand that the school nurse, or other designated person in case of absence of the school nurse (**including fieldtrips**) will supervise administration of medication

______I deem this child may **SELF-ADMINISTER** and **SELF-CARRY** their own medication with approval of the **school nurse.**

Physician Signature: ____ Date: ______________________

Address: ____ Phone: ___________________

Please note: The school nurse will assess the child's ability to be considered self-directed and/ or able to self-administer/carry their medications. The school nurse is responsible for making the final determination of self-direction and/or the ability to self-administer/carry medications.

B. To be completed by the parent/guardian:
I have consulted with my child's physician and agree with his/her recommendations. I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled container from the pharmacy.

Parent/guardian signature: ____ Date: ___________________

Telephone: Home: _____________________ Cell: _______________________ Work: _______________________

***Medication must be in original pharmacy labeled container with specific orders and name of medication.**
***Medication and refills must be brought to school by parent/guardian or responsible adult.**

Plan reviewed with parent(s)/guardian(s):
Nurse signature: ____ Date: ______________

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11. RELEASE OF INFORMATION FORM

This form allows exchange of important health information for your child between the School Nurse and their Medical Providers. All records obtained will be kept confidential. Please contact your School Nurse if you have any questions.

Student's Name		
DOB		
Parent/Guardian		
Address		
City	State	Zip
Phone		

I hereby authorize the release of information necessary for health care to:	
Return to: *(School Name)*	**Charter School of Inquiry**
Address	**404 Edison Street Buffalo, NY 14215**
Telephone/ fax	**716-833-3250/ fax 716-831-7947**

FROM	
Health Care Provider	
Address	
Phone	Fax
Regarding Name	
Specific Information	

Signature of Parent/Guardian	
Relationship to Student	
Date	

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12. 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, 2,4,7, &10. Your child may have a dental check-up during this school year to access 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/Guardian (Please Print)

Child's Name:

DOB:	Sex: Male Female	Will this be your child's first oral health assessment? YES NO

School: **Charter School of Inquiry**	Grade Level: K 1 2 3 4 5 6

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

Section 2. To be completed by the Dentist/ Dental Hygienist

The Dental condition of ____ on ____________________(date)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Circle one:

YES, the student listed above is in fit condition of dental health to permit his/her attendance at the public school.

NO, the student listed above is not in fit condition of dental health to permit his/her attendance at the public school.

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/ Dental Hygienist name and address (please print or stamp)	Dentist's/ Dental Hygienist'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 ½mm 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 cavity 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 cavity lesion is also present].

YES NO Dental Sealants Present
Other problems (specify): ____
III. Treatment Needs (check all that apply)
No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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