Pioneer Central School District at Arcade & Delevan Elementary
Mellisa Devitt, Principal
Tiffany Giannicchi, Principal

Arcade Elementary School
315 West Main Street
Arcade, NY 14009
716.492.9423

Delevan Elementary School
30 School Street
Delevan, NY 14042
716.492.9463

Dear Pioneer Families:

We are pleased to offer full day pre-school at both Arcade and Delevan Elementary Schools. We will be able to accommodate twenty students per classroom. Each classroom will have the teacher as well as two teaching assistants. In the event that our registrants exceed our number of available slots, a lottery will need to be held. Students selected through the lottery process will be placed, the remaining students may be added to a wait list.

Our school day begins at 8:45 a.m. and ends at 3:30 p.m. Your child may take the bus to and from school or you can transport your child. More information regarding the preschool program will be reviewed with you during the week of August 13th- August 17th. During this week we will conduct screenings and you will have an opportunity to connect with staff and ask questions.

We encourage you to complete the registration packet that is enclosed and return it to the office as soon as you are able. If you have any questions or concerns please contact the office at 716-492-9424.

Sincerely,
Mellisa Devitt, Arcade Principal
Tiffany Giannicchi, Delevan Principal

Pioneer Central School

Universal Pre-Kindergarten School Registration

Home of the Pioneer Panthers

Name of Student _____ **Date of Birth** _____

UPK - New Student Check List

☐ My child will be 4 years of age by December 1, 2018.
☐ I make a commitment to my child's regular attendance in the full day or half day Pre-K program 5 days/week for the 180 day school year.
☐ I am submitting the following information as required by the school district:

- Proof of Residency in Pioneer Central School District.
- Completed Registration Packet (attached)
- Copy of Birth Certificate & Soc. Security Card
- Copy of Custody Papers and/or Order of Protection (if any)
- Department of Social Services Foster Placement Form if appropriate
- McKinney-Vento Act if appropriate

I have completed this packet, have provided all the required documents and understand the Pre-K attendance requirements for my child and the parent participation expectation for me.

_____ Date _____
Print Parent/Guardian Name

_____
Parent/Guardian Signature

Pioneer
SCHOOL REGISTRATION FORM

Date of Requested Enrollment:_____ **Today's Date:**_____

Has student attended Pioneer Central School before? **Yes** _____ **No** _____

STUDENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

Social Security #:_____ Date of birth:_____

Telephone:( )_____ City & State of Birth: _____

Custody Papers on file? Yes___ No___ Order of Protection on file? Yes____ No____

Residence Address:

Street:_____

Town:_____Zip:_____

County:_____

Cell Phone:( )_____

Mailing Address (if different than residence):

P.O. Box:_____

Street: _____

Town:_____Zip:_____

E-Mail address _____

Ethnic Group (please select one):

Ethnicity (Choose one):
· Hispanic/Latino
· Not Hispanic/Latino

Race (Choose one or more, regardless of Ethnicity):
· American Indian or Alaska Native
· Asian
· Native Hawaiian or Other Pacific Islander
· Black or African American
· White

Gender:

- ❑ Male
- ❑ Female

Please Check All That Apply:

- ❑ Currently in Foster Care – DSS # _____
  Actual Home School District_____
- ❑ Enrolling but do not live in Pioneer District (non-Foster Care)
  Actual Home School District_____
- ❑ Migrant
- ❑ Immigrant/Refugee
  Country of Birth _____
  Home Language_____

Please list any Special Education service the student is currently receiving (i.e. OT, PT, Resource):

_____

Please list any other student attending the Pioneer District:

_____

Transportation

☐ Walker ☐ Parent Transports:_____

☐ Bus: _____ (If bus transportation is needed, please complete page 4)

PARENT/GUARDIAN INFORMATION – Please complete **ALL** lines below:

***NOTE: We presume both NATURAL parents share custody in divorce or legal separation agreements unless and until we receive a copy of the court order or separation agreement that pertains to the child's custody. Non-custodial parents are legally able to obtain school records unless otherwise noted in court document.**

Name:_____

Relationship:_____

Address if different from student address:

_____

_____

Home Phone if different from student phone:

( ) _____

Cell Phone # ( ) _____

E-Mail Address _____

Employer:_____

Employer Address:_____

_____

Employer Phone: ( )_____

Student Resides with: Yes____ No____

*Extra Mailing Required: Yes____ No____

Name:_____

Relationship:_____

Address if different from student address:

_____

_____

Home Phone if different from student phone:

( ) _____

Cell Phone # ( ) _____

E-Mail Address _____

Employer:_____

Employer Address:_____

_____

Employer Phone: ( )_____

Student Resides with: Yes____ No____

*Extra Mailing Required: Yes____ No____

**Extra mailing includes copies of report cards, progress reports, and academic intervention service notices. These are mailed when requested by the parent/guardian that does not reside with the student but is legally allowed to have this information.*

EMERGENCY CONTACTS - If unable to contact the above, please contact the following:

Name #1: _____

Relationship:_____

Address: _____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Name #2: _____

Relationship: _____

Address: _____

Home Phone: ( ) _____

Cell Phone: ( )_____

PIONEER SCHOOL DISTRICT

==========FAX==========

DATE:

TO: **FIRST STUDENT – BUS GARAGE**

FROM:

BUILDING:

RE: **Transportation Request as listed below effective _____**

❑ **New Student Enrollment** ❑ **Address Change for Current Student**

Parent/Guardian: Please fill in the section below if requesting bus transportation

Student Name:_____ Grade: _____

Home Phone Number: ( )_____ Building: _____

Parent/Guardian Name:_____

Address:_____
House No. Street Town Zip

- Will your child be getting **on** the bus in the morning at the above address? **YES ____ NO ____**
- Will your child be getting **off** the bus in the afternoon at the above address? **YES ____ NO____**

*If you answered **no** to either question above, please continue with the remainder of this form.*

Alternative Morning Pick up Information:

Name: _____ Phone: ( ) _____

Address:_____ _____
House No. Street Town

Alternative Afternoon Drop off Information:

Name: _____ Phone: ( ) _____

Phone: _____

Address: _____ _____
House No. Street Town

First Student Transportation Company Use . . .

Please complete and fax back or telephone the building listed:

Bus Lane #: _____ **Pick-up Time:_____** **Driver:_____**

Bus Stop Location: ❑ **Student's Home Address** ❑ **Group Pick up**

Pioneer Central School District

McKinney Vento Act – Transitional Housing Questionnaire

By completing this questionnaire, you help the district comply with the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Your truthful and accurate answers help the district identify services that the student may be eligible to receive.

Building this child attends: ____ Arcade ____ Delevan ____ Middle School ____ High School

Student Name: _____ Male ____ Female _____

Date of Birth (mo/day/yr) _____Current Age: _____ Grade: _____

Parent(s)/Legal Guardians Name: _____

Legal Address:_____

City: _____ NY Zip:_____

Telephone: _(_____)_____ Other Telephone _(____)_____

Do you also have preschool children? ___ Yes Ages: _____ No _____

1. I**s the student and or family living in temporary housing?** (check one)
   ____ in a shelter ____ in a motel or hotel ____ in a car
   ____ in a seasonal trailer park/campsite
   ____ with more than one family in a house or apartment
   ____ with friends or family members (other than parent/guardian)
   ____ none of the above

If you checked "none of the above", please sign the form and return to the school district.

2. **Does the living arrangement checked in question 1 result from a loss of housing or economic hardship?** ____ Yes ____ No ____ unsure

3. **The student lives with**
   ____ 1 parent ____ 2 parents ____ 1 parent & another adult
   ____ a relative, friend or other adult ____ alone with no adults
   ____ an adult who is not the parent or legal guardian

Signature _____ Date _____
Parent/Legal Guardian /Unaccompanied Youth

School Year: _____ 2018-2019 _____ 2019-20 _____2020-2021

For School Use Only
_____ Student not covered by McKinney-Vento Act
_____Student covered by McKinney-Vento Act
_____Follow up required…..forward form to:
Jeannene M. Wagner – Middle School

Date received:

Pioneer Central School
@ Arcade Elementary
Corners of Church and Main Streets
Arcade, NY 14009
Phone: 716-492-9426
Fax: 716-492-9453
lreynolds@pioneercsd.org

Dear Parents/Guardians,

September, and the start of UPK and Kindergarten, will be here before we know it! The items below will tell you what I need for your child to start school:

- COMPLETE immunization record MUST be handed in PRIOR to the start of school
- Physical Exam completed on or after 9/5/17 (out of state physicals will NOT be accepted)
- Health information packet:
  - Health History
  - Information for Medical Emergencies
- Dental certificate is requested (but not required)

Please return all records to the Arcade Elementary Health Office no later than the first day of school.

We are looking forward to having your child in school. If you have any questions please do not hesitate to contact me.

Thank you.
Sincerely,

Lisa Reynolds, RN
Arcade Elementary School Nurse

PIONEER CENTRAL SCHOOL
Information for Medical Emergencies

Child's Name _____
Last First Middle Nickname

Date of Birth _____ Sex _____ Grade ____

Home Address _____ Phone _____
Street Town/Village Zip

Mailing Address _____
PO Box/Street Town/Village Zip

Father/Guardian _____ Is Father living in home? _____
Place of work _____ Phone _____
Cell # _____

Mother/Guardian _____ Is Mother living in the home? _____
Place of work _____Phone _____
Cell # _____

Please list those persons who can be called in case your child is ill and you can't be reached:

Name _____ Phone _____
Relationship to the child Cell # _____

Name _____ Phone _____
Relationship to the child Cell # _____

Name _____ Phone _____
Relationship to the child Cell # _____

_____
Name of Physician Address Phone

Date _____ Parent/Guardian Signature _____

PIONEER CENTRAL SCHOOL HEALTH HISTORY

(MUST BE COMPLETED BY A PARENT/GUARDIAN)

Child's Name _____ Date of Birth _____

Has your child ever had any of the following? Please give dates.

_____ Chicken Pox _____

_____ Rheumatic Fever _____

_____ Diabetes _____

_____ Seizures _____

Caused by trauma _____

Caused by fever _____

Caused because of Epilepsy _____

_____ Tuberculosis _____

_____ Tuberculosis in associates _____

_____ Frequent headaches _____

_____ Ear Infections _____

_____ Hearing loss/uses hearing aids _____

_____ Visual difficulties or wears glasses _____

_____ Kidney/Bladder problems _____

_____ Congenital Abnormalities _____

_____ Heart Disease/Murmur _____

_____ Asthma/Reactive Airway Disease _____

_____ Allergies (non-medication) _____

_____ Medication allergies _____

_____ Operations _____

OVER

_____ Serious Injury _____

_____ Concussion _____

_____ Skin Problems _____

_____ Bowel Problems _____

_____ ADHD/ADD _____

_____ Behavioral Diagnosis _____

_____ OTHER _____

_____ Does your child take any daily medications? If yes, please list the medications and dosage_____

_____

_____ Does your child take any medications prescribed as needed? If yes, please list the medications and dosage_____

_____

ADDITIONAL COMMENTS;

Date _____

Parent/Guardian Signature

If at any time your child has a change in their health history, please contact the school nurse. Thank you.

Recommended / Sample Form

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

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

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

Significant Medical/Surgical History: ❑ See attached _____

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

PHYSICAL EXAM

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

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

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

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

MEDICATIONS

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

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

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

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

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

❑ **Specify medical accommodations needed for school:** _____ ❑ None

❑ **Known or suspected disability:** _____ ❑ Please monitor

❑ **Restrictions:** _____ ❑ Please monitor

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

OPTIONAL INFORMATION, if known

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

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

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 2/08*

Dental Health Certificate - Optional

Parent/Guardian: Please complete Section 1 and take the form to your dentist/dental hygienist for an assessment. Request your dentist/dental hygienist to fill out Section 2. Return the completed form to your child's teacher 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

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

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

I. 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**

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

II. Treatment Needs (check all that apply)

☐ **No need for Treatment**

☐ **Urgent Treatment –** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care –** amalgams, composites, crowns, etc.

☐ **Preventive Care** – sealants, fluoride treatment, prophylaxis, mouthguard etc.

☐ **Other** – periodontal, orthodontic treatments

Please note _____

The Dental Health condition of _____ on _____ (date of exam) Check one:

☐ **Yes, The student listed above *is* in fit condition of dental health to permit him/her attendance at the public schools.**

☐ **No, The student listed above *is not* in fit condition of dental health to permit him/her attendance at the public schools.**

Dentist's Name and Address (Please Print or Stamp):

Dentist/Dental Hygienist Signature:

Date of Exam: / /

* The dental health condition of the student when the exam is made and the date of exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.

PIONEER SCHOOL DISTRICT

==========FAX==========

DATE:

TO: **FIRST STUDENT – BUS GARAGE**

FROM:

BUILDING:

RE: **Transportation Request as listed below effective _____**

❑ **New Student Enrollment** ❑ **Address Change for Current Student**

Parent/Guardian: Please fill in the section below if requesting bus transportation

Student Name:_____ Grade: _____

Home Phone Number: ( )_____ Building: _____

Parent/Guardian Name:_____

Address:_____
House No. Street Town Zip

- Will your child be getting **on** the bus in the morning at the above address? **YES** ____ **NO** ____
- Will your child be getting **off** the bus in the afternoon at the above address? **YES** ____ **NO**____

*If you answered **no** to either question above, please continue with the remainder of this form.*

Alternative Morning Pick up Information:

Name: _____ Phone: ( ) _____

Address:_____ _____
House No. Street Town

Alternative Afternoon Drop off Information:

Name: _____ Phone: ( ) _____

Phone: _____

Address: _____ _____
House No. Street Town

First Student Transportation Company Use . . .

Please complete and fax back or telephone the building listed:

Bus Lane #: _____ **Pick-up Time:**_____ **Driver:**_____

Bus Stop Location: ❑ **Student's Home Address** ❑ **Group Pick up**

FORM
SREI

ARCADE ELEMENTARY SCHOOL
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.

English Only

Name of School: ARCADE ELEMENTARY	
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 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 (√) **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:** 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

Signature of Parent/Guardian/Other _____ Date _____

Relationship to Student (please check one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

See reverse for important message to Parents/Guardians and Confidentiality Procedures and Regulations.

ARCADE ELEMENTARY SCHOOL
STUDENT RACIAL AND ETHNIC IDENTIFICATION

FORM
SREI

To the Parent/Guardian: The *SAMPLE SCHOOL DISTRICT* has adopted a policy which requires the collection and recording of the ethnic identity of students in the *SAMPLE SCHOOL DISTRICT* 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 on the back of this page. Put a check (√) in the box for the category or categories which best describe your child. The *SAMPLE 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 information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

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

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

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number

Please complete the form on the reverse side of this page

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

Please type or print clearly

DISTRICT

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH Month Day Year

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME / POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION:

☐ Possible LEP

☐ English Proficient

(✓ 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 _____ (specify) ☐ Does Not Read
6. What language(s) does the student write? ☐ English ☐ Other _____ (specify) ☐ Does Not Write
7. In your opinion, how well does the student understand, speak, read and write English?

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

_____ *Signature of Parent/Guardian/Other*

_____ Month Day Year *Date*