FOR OFFICE USE ONLY:

Student Name:_____

Student Number:_____ **Gen:**_____

Family Number:_____**Grade:**_____

School:_____

Start Date:_____**Grad Year:**_____

NEW STUDENT WITH IEP REGISTRATION

Please be sure to submit the supporting documentation below with your registration forms along with any custody documentation if applicable. Please submit your completed paperwork by scanning/emailing to registrar@niskyschools.org, or by dropping them off at the District Office which is located at 1430 Balltown Rd and is open Monday through Friday from 8:00am until 4:00pm. There is a locked mailbox just inside the door that you can place your forms in. You will receive an email from the Registrar's Office if anything is missing.

Proof of Residence (Must submit a minimum of 2, one from Row A and one from Row B)					
Row A	☐ Signed Lease OR Mortgage Statement	☐ Homeowners OR Renter's Insurance Bill	☐ Closing Statement OR Deed	☐ Contract of Sale	☐ Property Tax Bill/Receipt
Row B	☐ Utility or other bills	☐ Income Tax	☐ Membership documents based on residency	☐ Voter Registration documents	☐ Local, State or Government issued ID documents
	☐ Pay Stub	☐ Official driver's license, learner's permit or non-driver identification	☐ Sworn Statement by third-party (landlord, etc.)	☐ Evidence of Custody of Child (custody orders, guardianship papers, etc.)	☐ Other (Must be approved by Registrar before submittal)

Proof of Birth (*Must submit one of the following*)					
☐ Birth Certificate	☐ Passport	☐ Driver's License	☐ School photo identification card with date of birth	☐ Consulate Identification card	☐ Local, State or Government issued identification cards or documents
☐ Military dependent identification card	☐ Hospital or health records	☐ Native American tribal documents	☐ Court orders or other court issued documents	☐ Records from non-profit international aid agencies and voluntary agencies	

Proof of Parental Relationship (*Must submit one of the following*)		
☐ Birth Certificate & parent photo ID	☐ Court custody documents & custodian photo ID	☐ Baptismal certificate & parent photo ID
☐ Court adoption documents & parent photo ID	☐ Court guardianship documents & guardian photo ID	☐ Notarized affidavit of emancipation

Other:	
☐ Immunization Records	☐ Release Forms

PLEASE BE SURE THAT ALL OF THE ABOVE REQUIREMENTS HAVE BEEN MET BEFORE SUBMITTAL

FOR OFFICE USE ONLY: **Services:**_____

_____
REGISTRAR'S SIGNATURE

_____
DATE

_____
ZONE

Revised 10/20/2025

FOR OFFICE USE ONLY:

Student Name:_____

Student Number:_____ **Gen:**_____

Start Date:_____**Grade:**_____

School:_____

Services:_____

Student's Name_____

Primary Phone Number _____ ☐ Male ☐ Female

Last Grade Completed _____ Grade Entering _____

Student's Permanent Address _____

Mailing Address (if different from above) _____

Date of Birth _____ Place of Birth _____

Last School Attended _____

Address of Last School _____

Name of Parent/Guardian #1 _____ Relationship:_____

Address (if not the same as above) _____

Cell Phone _____ Preferred Language:_____

Email Address _____

Name of Parent/Guardian #2 _____ Relationship:_____

Address (if not the same as above) _____

Cell Phone _____ Preferred Language:_____

Email Address _____

We have a form available which can be completed if there is another address that you would want school mailings sent (e.g. second parent.) Would you like a copy of this form? ___ Yes ___ No

Please list all other children in the home (Birth to Age 18):

Name	Gender	Birthdate	School

Please list 3 Emergency Contacts (other than parents)

Contact #1: Name _____ School Pick Up: ☐ Yes ☐ No

Phone Number: _____ Relationship_____

Contact #2: Name _____ School Pick Up: ☐ Yes ☐ No

Phone Number: _____ Relationship_____

Contact #3: Name _____ School Pick Up: ☐ Yes ☐ No

Phone Number: _____ Relationship_____

Has your child ever received **Special Education Services**? ___ Yes ___ No

Does your student have an **Individualized Education Program (IEP)**? ___ Yes ___ No

Does your student have a **504 Plan**? ___ Yes ___ No (If yes, please include a copy upon submittal of paperwork)

What language(s) are spoken in the students' home or residence? ☐ English ☐ Other:_____

What was the first language your child learned? ☐ English ☐ Other:_____

What is the Home Language of each parent/guardian?

Parent 1: _____ Parent 2: _____ Guardian: _____

What language is your preferred method of communication: _____

What language(s) does your child understand?_____

What language(s) does your child speak? _____ ☐ Does not speak

What language(s) does your child read? _____ ☐ Does not read

What language(s) does your child write? _____ ☐ Does not write

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

- FOR OFFICE USE ONLY- -

Name/Position of Qualified Personnel Reviewing and Conducting Individual Interview:

Oral Interview Necessary: ☐ Yes ☐ No

Name: _____ Position:_____

*Please be sure to complete the contact name and email address below. Failure to do so **will result in a delay** to your child's registration process. If you are unsure of this information, please call your child's previous school and they will be able to assist you.*

Today's Date: _____ Expected Start Date at Niskayuna School:_____

Student's Name _____Grade_____

I hereby request and authorize _____
Name of school from which you are transferring

_____ _____
Name of person to contact Email address of contact

_____
City and state of previous school

_____
Signature of Parent/Guardian

Please send the following information to Niskayuna Central Schools:

TO BE COMPLETED BY PREVIOUS SCHOOL:

1. Academic Records (transcript of grades, including current grades from last marking period to withdrawal date)

2. English as a New Language:
   Did this student receive services? ___ Yes ___ No If yes, please circle the proficiency level:

ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

3. Standardized test results (please include Competency testing if student is from another New York State school)

- - - - - - - FOR NISKAYUNA REGISTRAR USE ONLY - - - - - - -

Please send the information listed above to:

____ **Birchwood Elementary School:** BirchwoodESRecords@niskyschools.org

____ **Craig Elementary School:** CraigESRecords@niskyschools.org

____ **Glencliff Elementary School:** GlencliffESRecords@niskyschools.org

____ **Hillside Elementary School:** HillsideESRecords@niskyschools.org

____ **Rosendale Elementary School:** RosendaleESRecords@niskyschools.org

____ **Iroquois Middle School:** Iroquois MSRecords@niskyschools.org

____ **Van Antwerp Middle School:** VanAntwerpMSRecords@niskyschools.org

____ **Niskayuna High School:** NiskayunaHSRecords@niskyschools.org

Student Name: _____

Gender: Male _____ Female _____ Date of Birth: ____ /____ /_____ Grade: _____

Address: _____ Phone: _____

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

Where is the student currently living? (Please check one)

_____ In a shelter
_____ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled up")
_____ In a hotel/motel
_____ In a car, park, bus, train or campsite
_____ Other temporary living situation (Please describe): _____
_____ In permanent housing

_____
Print name of parent, guardian or student (for unaccompanied homeless youth)

_____
Signature of parent, guardian or student (for unaccompanied homeless youth)

_____
Date

Name of Student (Last, First, Middle): _____

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. Check the box that best describes your child. Check only ONE box.

☐ YES, Hispanic ☐ NO, not Hispanic

2. Select one or more races from the following five racial groups. For question (2) check all 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 and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ 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 peoples Hawaii, Guam, Samoa or other Pacific Islands.

☐ BLACK OR AFRICAN AMERICAN: 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: _____

Relationship: _____ Date: _____

TO THE PARENT/GUARDIAN: In accordance with Federal guidelines, the Niskayuna Central School District is collecting and recording the ethnic identity of students using Federal categories and definitions. 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. This 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
-Analyze differences in academic performance, attendance and completion of school

Please review the above information and be sure that you have checked the boxes that best describe your child. The Niskayuna Central School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the 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
This form will be filed in the student's permanent record as confidential information.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 disclosure access to student records and unauthorized release of any student record information identifiable by student name and student identification number.

Please give any information you feel would be helpful about your child:

Name: _____ Grade: _____

Parent/Guardian #1: _____ Phone: _____

Parent/Guardian #2: _____ Phone: _____

Family Physician/Pediatrician: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital (in case of emergency)_____

Growth and Development

Birth weight: _____ Delivery (normal or premature): _____ Walked at age: _____ Talked at age: _____

Check if your child had had any of the following:

- □ Chicken pox
- □ Diphtheria
- □ German Measles
- □ Mumps
- □ Measles
- □ Pneumonia
- □ Poliomyelitis
- □ Pneumatic Fever
- □ Scarlet Fever
- □ Tuberculosis
- □ Whooping Cough
- □ Contact with TB

Check if your child has a history of any of the following:

- □ Asthma or allergies
- □ Epilepsy
- □ Heart Disease
- □ Eye Condition
- □ Ear Condition
- □ Frequent colds/sore throats
- □ Diabetes

Please indicate if your child is under treatment for any conditions and describe:

_____

_____

Please indicate if there is a history of any hospitalizations, significant injuries or surgery and describe:

_____

_____

Please indicate if your child has any allergies and describe:

_____

_____

Medications

Is your child on any daily medications: Yes _____ No _____

Medication 1: _____ Taken for: _____ Dose: _____ Keep in Nurse's Office? _____

Medication 2: _____ Taken for: _____ Dose: _____ Keep in Nurse's Office? _____

Medication 3: _____ Taken for: _____ Dose: _____ Keep in Nurse's Office? _____

NISKAYUNA CENTRAL SCHOOL DISTRICT
Office of Student Support Services
1301 Hillside Avenue
Niskayuna, NY 12309
Phone - (518) 382-2525 FAX – (518) 382-2526

Consent to Obtain/Release of Information

Concerning: _____ Date of Birth: _____

This consent to obtain and/or release information authorizes the Niskayuna Central School District's Special Education Programs and Services office to:

____ Release Information/Records to

____ Obtain Information/Records from

Agency: _____ Phone: _____

Address: _____

City/State: _____ Zip _____

Contact Person: _____ FAX: _____

This consent and release includes any and all medical, psychological, or educational information they may have concerning the above referenced individual.

Signature: _____ Date: _____

Address: _____

City/State: _____ Zip _____

Home Phone: _____ Work Phone: _____

Witness: _____ Date: _____

8/2021

Niskayuna Central School District
Committee on Special Education
Student Support Services
1301 Hillside Avenue
Niskayuna, NY 12309

October 7, 2021

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

This form has been adapted from the U.S. Department of Education's model Notification Form[1]

INTRODUCTION

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

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

Before your school district or county can ask you to provide consent to check with the New York State Department of Health whether your child has public benefits or insurance (e.g., Medicaid coverage and/or a Client Identification Number (CIN)), and to access these benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. Whether or not you provide consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT

34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)

Before your school district (or for preschool students, your county) can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time.

This consent requirement has two parts.

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing (sharing) personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the school district will (1) identify the records (or information) about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

[1] For the full Suggested Model for Written Notification of Parental Rights regarding Use of Public Benefits or Insurance developed by the U.S. Department of Education, see: http://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/accmodelwrittennotification-6-11-13.pdf

2. Consent to check with the New York State Department of Health: whether your child has a CIN/public benefits or insurance (Medicaid) coverage, and bill your child's public benefits or insurance (Medicaid) program: Your consent must include a statement specifying that you understand and agree that your school district or county, for preschool, may use you or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS
34 CFR §300.154(d)(2)(i)-(iii) and 8 NYCRR §200.5(b)(8)(ii)(b)-(d)

The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for or enroll in a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.
3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:
    a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;
    b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;
    c. increase your premium or lead to the cancellation of your public benefits or insurance; or
    d. cause you to risk the loss of your child's eligibility for home and community-based waiver that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district or county, for the provision of preschool special education, to use your or your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see:
http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parentalconsent.htm

Niskayuna Central School District
Student Support Services
1301 Hillside Avenue
Niskayuna, NY 12309 (518-382-2525)
Medicaid Consent

Dear Parent/Guardian:

Medicaid Insurance: Yes or No (Please circle)

If your child has Medicaid Insurance please fill in the Client Identification Number (CIN) which consists of 2 letters, 5 numbers and 1 letter (Example AB12345C**): CIN:_____OR Social Security Number:_____**

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client IdentificationNumber (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose. **I, _____as the parent/guardian of _____** have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

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

I understand that:
• Providing consent will not impact my child's/my Medicaid coverage;
• Upon request, I may review copies of records disclosed pursuant to this authorization;
• Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
• I have the right to withdraw consent at any time; and
• The school district must give me annual written notification of my rights regarding this consent.

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

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

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

Parent/Guardian Signature: _____

Print Name:_____Date:_____