

MILFORD CENTRAL SCHOOL ENROLLMENT CHECKLIST

- ☐ Verification of Residency
(Any official paper/bill with primary parent Name and physical address)
 - ☐ Birth Certificate
 - ☐ Immunization Records & Proof of Physical (within the last 12 months)
 - ☐ Custody or Court Order, if applicable
 - ☐ Registration Form
 - ☐ Request for Records (grades 1-12 only)
 - ☐ Home Language Questionnaire
 - ☐ Dental Health Certificate
 - ☐ Student Health History/Emergency Form
 - ☐ Consent for disclosing information
 - ☐ Emergency Closing Information
 - ☐ Technology Use Agreement
-
- ☐ For Pre-K please include the Universal Pre-Kindergarten Application
 - ☐ For Kindergarten, please include the Kindergarten Parent Questionnaire.

Milford Central School REGISTRATION FORM

Please Print

Please Print

Office Use Only			
Student ID#	Building	School Year	
Grade Assigned	Entry Date	Advisor/Teacher	1 st Period Rm. No.

STUDENT NAME _____ SEX _____
(First) (Middle Initial) (Last) (M/F)

BIRTHDATE _____ BIRTHPLACE _____
(MM/DD/YYYY) (City, State, Country)

US CITIZEN_(Y/N) If no, indicate citizenship _____

Date of entry into US _____, # of years in US Schools _____, Country of Origin _____

Ever Attend NYS School _____ If yes, Indicate District/School _____ If yes, Indicate School/Yr _____

ETHNICITY: Hispanic – Yes or No RACE: Please select one below 1 American Indian or Alaskan Native 2 Black or African American 3 Asian 4 White 5 National Hawaiian/Pacific Islander	Language Spoken at Home _____ Active Military? _____ ___Y ___N	Last School Attended NAME _____ ADDRESS _____ _____ Date Left _____ Last Grade Completed _____
Student Residential Address 911 Address _____ PO Box # (If applicable) _____ CITY _____ STATE _____ ZIP _____ HOME PHONE _____ MOBILE PHONE _____		Is your current address a temporary living arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this temporary living arrangement due to loss of housing or economical hardship? <input type="checkbox"/> Yes <input type="checkbox"/> No Temporary/Alternative Living Arrangements: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please check off current living arrangements: <input type="checkbox"/> Shelter <input type="checkbox"/> Car <input type="checkbox"/> With Relatives <input type="checkbox"/> Train/Bus Station <input type="checkbox"/> Abandoned Building <input type="checkbox"/> Campground <input type="checkbox"/> Hotel/Motel Please identify living arrangements _____ _____

G NAME _____
U (First) (Middle) (Last)
A
R 911 Address _____
D
I PO Box # (if applicable) _____
A
N CITY _____ STATE _____ ZIP _____

 HOME PH _____ WORK PH _____ MOBILE PH _____

 Email _____

 PLACE & ADDRESS EMPLOYMENT _____

Receive Mailings YES NO
Relationship to student _____ Living with Student YES NO
Parent Portal YES NO

G NAME _____
U (First) (Middle) (Last)
A
R 911 Address _____
D
I PO Box # (if applicable) _____
A
N CITY _____ STATE _____ ZIP _____

 HOME PH _____ WORK PH _____ MOBILE PH _____

 Email _____

 PLACE & ADDRESS EMPLOYMENT _____

Receive Mailings YES NO
Relationship to student _____ Living with Student YES NO
Parent Portal YES NO

If Student is not living with both parents, who has legal custody? _____

Are there any custody restrictions of which we should be made aware? Please specify. _____

C O N T A C T NAME _____
(First) (Middle) (Last)
911 Address _____
PO Box # (If Applicable) _____
CITY _____ STATE _____ ZIP _____
HOME PH _____ WORK PH _____ MOBILE PH _____
Email _____
PLACE & ADDRESS OF EMPLOYMENT _____

Receive Mailings
YES NO
Relationship to student

Living with Student
YES NO
Parent Portal
YES NO

C O N T A C T NAME _____
(First) (Middle) (Last)
911 Address _____
PO Box # (if Applicable) _____
CITY _____ STATE _____ ZIP _____
HOME PH _____ MOBILE PH _____ WORK PH _____
Email _____
PLACE & ADDRESS OF EMPLOYMENT _____

Receive Mailings
YES NO
Relationship to student

Living with Student
YES NO
Parent Portal
YES NO

OTHER CHILDREN IN FAMILY

NAME _____ SEX: _____ DOB _____ AT RESIDENCE _____
(M/F) (MM/DD/YYYY) (Y/N)
NAME _____ SEX: _____ DOB _____ AT RESIDENCE _____
(M/F) (MM/DD/YYYY) (Y/N)
NAME _____ SEX: _____ DOB _____ AT RESIDENCE _____
(M/F) (MM/DD/YYYY) (Y/N)
NAME _____ SEX: _____ DOB _____ AT RESIDENCE _____
(M/F) (MM/DD/YYYY) (Y/N)

OTHER PERSONS LIVING IN THE RESIDENCE

NAME _____ SEX: _____ DOB _____
(M/F) (MM/DD/YYYY)
NAME _____ SEX: _____ DOB _____
(M/F) (MM/DD/YYYY)

BAND: Is the student interested in joining Band? Yes No (Must be in 4th grade or higher)

EMERGENCY INFORMATION

PHYSICIAN _____ PHONE _____ HOSPITAL CHOICE _____
ANY DISABILITIES _____ If yes, specify _____ 504 _____ IEP _____

Signature of Parent/Guardian _____ Date _____

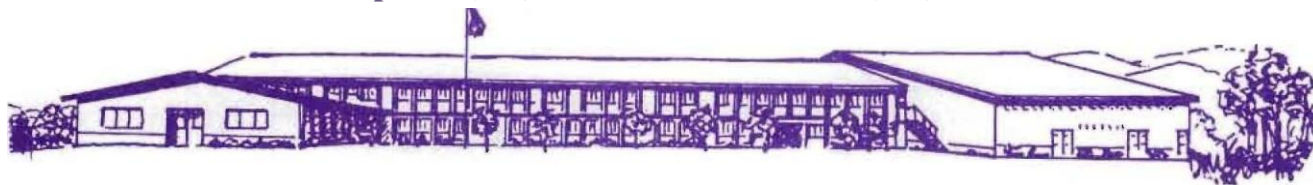
Signature of School Official who registered child _____ Date _____

DISTRIBUTION (For office use only)

Don Harvey Jolene Chase Brenda Lang Cyndy Marino Library
Michelle Dibble Lorre Gregory Dan Scalfani (if applicable) Nicole Lippitt Teacher _____

Milford Central School

PO Box 237 • West Main Street
Milford, New York 13807-0237
Telephone (607) 286-3341 or 3349 Fax (607) 286-7879



STUDENT RECORD TRANSMITTAL REQUEST

Student Name: _____ Date of Birth: _____

Other Names(s) Student has Used: _____ Grade: _____

School Last Attended: _____

Requesting Inf. From (Agency): _____

Agency Address: _____

I, _____, the parent or legal guardian of the above-named student, hereby authorize Milford Central School District to send/request records as indicated in Section A and B below for purposes of school placement and/or educational planning.

A. RECORDS FOR SCHOOL

- Academic Records
- Health Records
- Standardize Test Results
- Birth Certificate
- Custody/Court Orders (if applicable)

B. SPECIAL EDUCATION AND PSYCHOLOGICAL SERVICES (IF APPLICABLE)

- Medical Records
- Psychological Records
- Social History
- Related Service Evaluations (Speech, Occupational Therapy, Physical Therapy, Vision, Hearing, etc.)
- Students Individual Education Plan (IEP)

I understand that the student and /or I may, at my expense, receive personally from the school district upon my written request a copy of any of the above released records to be subject to interpretation as necessary by competent school personnel and that I may review and challenge the content to such released records.

Signature: _____
(Parent or Legal Guardian) (Relationship to Student)

REQUESTING SCHOOL: Milford Central School
PO Box 237, West Main Street
Milford, New York 13807

PERSON REQUESTING INFORMATION: _____
Jennifer Johnson/Nicole Lippitt Date
School Counselors



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate Commissioner Office of
Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Person in Parental Relation:
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 in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
Month	Day	Year
<input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<input type="checkbox"/> Guardian(s)		_____
			specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			specify

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT
INFORMATION SYSTEM:

District Name (Number) & School:

Address:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure

☐ ☐ ☐ *If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been **referred** for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete 10b below*

10b. **If referred for an evaluation*, has your child ever **received** any special education services in the past?

☐ No ☐ Yes – Type of services received: _____

Age at which services received *(Please check all that apply):*

☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

Date

Relationship to student: ☐ Parent ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL
INTERVIEW:

Mo. Day Yr.

OUTCOME OF
INDIVIDUAL
INTERVIEW:

- ☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL
ADMINISTRATION:

Mo. Day Yr.

PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

- ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

NYS Dental Health Certificate (Form D-2)

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist 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 or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date ____/____/____

Sex: Male Female

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

School Name:

Grade:

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

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date _____

Section 2 ~ To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

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

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

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 Name and Address (pls print or stamp)

Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

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**

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.

Milford School District

STUDENT HEALTH HISTORY / EMERGENCY FORM

Student Name:	DOB:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	Grade:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O
Parent/Guardian: (Person completing this form)	Home Phone:	Date:	
Place of Employment:	Cell Phone:		
Address:	Work Phone:		
Hospital: <input type="checkbox"/> Bassett <input type="checkbox"/> Fox <input type="checkbox"/> Other			
Physician's Name:	Dentist Name:		
Address:	Address:		
Phone Number:	Phone Number:		

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	<input type="checkbox"/>	<input type="checkbox"/>	
Seen a medical specialist	<input type="checkbox"/>	<input type="checkbox"/>	
Had/has allergies:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other
Specific Allergy			
Prescribed an epinephrine pen?	<input type="checkbox"/>	<input type="checkbox"/>	
Carries epinephrine pen on their body?	<input type="checkbox"/>	<input type="checkbox"/>	
Asthmatic	<input type="checkbox"/>	<input type="checkbox"/>	
Has a treatment plan	<input type="checkbox"/>	<input type="checkbox"/>	
Been hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	
Had an operation	<input type="checkbox"/>	<input type="checkbox"/>	
Had an injury requiring an Emergency Room visit	<input type="checkbox"/>	<input type="checkbox"/>	
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>	
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Had an eye examination	<input type="checkbox"/>	<input type="checkbox"/>	
Had/has a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
Color blind	<input type="checkbox"/>	<input type="checkbox"/>	
Had a hearing test	<input type="checkbox"/>	<input type="checkbox"/>	
Had/has a hearing problem or condition/ infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant
Dental injury, bridge, braces or mouthpiece	<input type="checkbox"/>	<input type="checkbox"/>	
Have any family members under the age of 50 ever:	YES	NO	If Yes, please specify:
Had a heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Had other serious health problems	<input type="checkbox"/>	<input type="checkbox"/>	

CHECK ALL THAT APPLY TO YOUR CHILD: (if yes, check and enter date. Explain on the next page)

- | | |
|--|---|
| <input type="checkbox"/> ADHD/ADD
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma/trouble breathing
<input type="checkbox"/> Autism/Asperger
<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Developmental disability
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> German Measles
<input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Heart Conditions/disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Measles
<input type="checkbox"/> Mental Health Condition {depression, eating disorder, anxiety, OCD, ODD, etc.} | <input type="checkbox"/> Mumps
<input type="checkbox"/> Nephritis
<input type="checkbox"/> Neuromuscular disorder
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Scarlet fever (tina)
<input type="checkbox"/> School Based Health Enrollment
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Single Organ (<input type="checkbox"/> kidney, <input type="checkbox"/> testicle)
<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Tuberculosis or Contact with TB
<input type="checkbox"/> Urinary Condition
<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Other serious illnesses? |
|--|---|

Please list any additional concerns: (use additional sheet if necessary)

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

*Must provide documentation from provider.

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> Inhaler/nebulizer/peak-flow monitoring <input type="checkbox"/> special diet (please provide Dr.'s orders gluten/lactose allergies)

AUTHORIZATION: I/We, being the parent(s)/guardian(s) of the above-named student, do hereby appoint an authorized Milford Central School faculty member to act in my/our behalf to authorize unexpected medical, dental, surgical care and hospitalization for the above-named student during the period of my/our absence, from _____ through _____.

I/We expect, however, that efforts will be made to contact me/us for authorization when treatment is to be undertaken.

EMERGENCY CONTACTS: Please indicate two people who can be notified in case a member of the immediate family cannot be reached in an emergency.

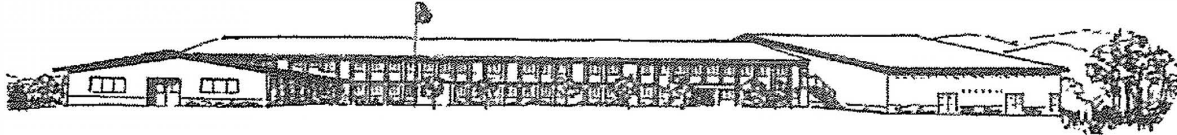
Name:	Name:
Relation:	Relation:
Phone:	Phone:

Please remember to contact the school nurse, if any information should change during the year.

Parent/Guardian Signature: _____ Date: _____

Milford Central School

Box 237 • West Main Street
Milford New York 13807-0237
Telephone (607) 286-3341 or 3349



Student Name	M / F / O	Date of Birth _ / _ / _
Student Complete Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED BELOW.

7. Name and address of health provider(s) or entity(ies) to exchange information with Milford Central School District, 42 West Main Street, Milford NY 13807

1. _____
2. _____
3. _____
4. _____

8. (a) Specific information to be released and/received:

☐ Medical Information

☐ Educational Records

☐ Any relevant information to assist with educational planning

Include:

☐ Alcohol/Drug Treatment

☐ Mental Health Information (Initials _____,)

☐ HIV-Related Information

8.(b) Authorization to Discuss Health and/or relevant information:

By initialing here (initial) _____ I authorize the above health providers and/or entities to discuss my health information with the Milford Central School District

9. Reason for release of information:

☐ Assessment and coordination of services for educational planning

☐ At the request of individual

☐ At the request of MCSD

10. Date or event on which this authorization will expire: _____

Upon High School Graduation, transfer to another district, or at the request of the parent/guardian

All items on this form have been completed and my questions about this form answered. In addition, I will be provided a copy of this form.

Signature of individual or representative

Authority as Representative

Date

Milford Central School
Milford, New York 13807

Emergency School Closing Information

Please complete the following information. It will be used to update our files as well as let us know where your child should go in the event of an emergency early school closing.

Teacher's Name _____ Grade _____

Child's Full Name _____

Street Address of Child _____

Information for Parent/Guardian #1

Name: _____

Address: _____

Email _____ Home Number: _____

Cell: _____ Work Number: _____

Information for Parent/Guardian #2

Name: _____

Address: _____

Email: _____ Home Number: _____

Cell: _____ Work Number: _____

I authorize the school, in the event of an emergency early school closing, to send or take my child as noted below:

PLEASE NOTE: **WE DO NOT CALL YOU IF WE CLOSE EARLY.**

☐ My child will take the same bus as every day.
Name of bus driver _____ Bus Number _____

☐ My child will walk home

☐ My child will walk to the sitters
Name and phone number of sitter _____

☐ My child will walk to a different location as noted: _____

☐ My child will take same bus, but different location: _____

☐ My child will take a different bus and different location as noted. (Please include the name of the bus driver and bus number that they will be taking. _____

Parent/Guardian Signature _____ Date _____

Please return this form your classroom teacher as soon as possible.

PLEASE NOTE: **WE DO NOT CALL YOU IF WE CLOSE EARLY.**

**CHROMEBOOK WILL NOT BE GIVEN TO STUDENT UNTIL THE SIGNATURE PAGE
IS COMPLETED AND RETURNED.**

2023-2024



MILFORD CENTRAL SCHOOL

PO Box 237, 42 W. Main St., Milford, NY 13807

Tel: (607) 286-3341 Fax: (607) 286-7879

MCSD Computer & Technology Committee

Re: Acceptable Use Policy and Chromebook Use Agreement

Dear Parent/Guardian/PIPR's,

We are pleased to offer students of the Milford Central School District access to the district computer network and educational technology. To gain access to the Internet and MCSD Network, all students must obtain Parent/Guardian/PIPR's permission and must sign and return the attached form to the student's teacher.

Use of the Internet is a privilege and students will retain this privilege as long as they remain responsible users. Use of the Network, Internet, and other Technologies can be denied, suspended or revoked at any time for failure to use this access in an appropriate manner. Other disciplinary actions may follow.

The Internet is a valuable resource for Parent/Guardian/PIPR's and community members to access and prepare for various school programs and events. The District and affiliated organizations (MEF/associated colleges) may post or publicize student work or photos on paper and their website and Milford school's official social media in accordance with the Family Educational Rights Act Policy that is available on the school's website.

If you have any questions or concerns, please call any member of the Computer Technology Committee.

Sincerely,
Technology Committee



**CHROMEBOOK WILL NOT BE GIVEN TO STUDENT UNTIL THE SIGNATURE PAGE
IS COMPLETED AND RETURNED.**

**The following Acceptable Use Policy and Chromebook Agreement must be read and signed by both
parties.**

Milford Central School Educational Technology Acceptable Use Agreement
Policy Reference: #4526

Students in the Milford Central School District have access to vast amounts of information through our computer networks and the Internet using **Information and Communication Technologies (ICT)**. Accordingly, the school has established a policy for the use of the technology along with rules governing the behavior of students who access it.

All student members of the MCS District are expected to follow certain measures to ensure the safety and security of students and the school's network.

Students shall:

- follow the Student Code of Conduct. This includes using only appropriate language when online and avoiding any website which may contain inappropriate content and/or language;
- follow rules for using resources, time limits, and printing instructions provided to them by staff members;
- follow appropriate procedures for care of all school technology;
- take precautions to prevent others from gaining access to their individual accounts;
- report violations of these rules to staff;
- properly cite material gleaned from Internet sources and follow copyright rules;
- adhere to all district policies; and
- respect the privacy and dignity of students and teachers at all times.

Students shall not:

- play games not intended for educational purposes, conduct commercial activities for profit, advertise products, incur any financial liability or conduct political lobbying;
- use the Internet illegally in ways that violate federal, state, or local laws or statutes or to access or transmit pornographic and educationally inappropriate material or files which are dangerous to the integrity of the network;
- lend their logins and passwords to anyone;
- log on with someone else's account or vandalize, which is defined as any malicious attempt to harm or destroy data of another user on the Network/Internet and includes the uploading or creation of computer viruses;
- interfere with the ability of other users to make effective use of the school's technology resources;
- use email, social networking sites, or other systems for personal communication;
- download, copy, remove, or alter school software or install any personal software on school ICT;
- falsifying one's identity to others while using the Network/Internet and ICT;
- change any files that do not belong to the user;
- engage in cyberbullying activities;
- reveal their personal information including home address or phone number(s) or those of others.

**CHROMEBOOK WILL NOT BE GIVEN TO STUDENT UNTIL THE SIGNATURE PAGE
IS COMPLETED AND RETURNED.**

Property

Technology, software, and the Internet, including email provided by MCSD (if available), are the property of the school district. The MCS District reserves the right to access all Internet and ICT activity.

Chromebook Use Agreement

Receiving Your Chromebook:

Parent/Guardian/PIPR's & Students must sign and return the Chromebook Acceptable Use Agreement Sign-off document before the Chromebook can be issued. This document must be signed before receiving one Chromebook, case, and power cord.

Training:

Students will be trained on how to use the Chromebook by the distributing teacher. Training documents and videos will be available online for students to refer to when needed.

Return:

Student Chromebooks and accessories (power cord and case) will be collected at the end of each school year for maintenance over summer vacation. Students will be re-assigned a Chromebook each year while enrolled at MCS.

Repair:

Loaner Chromebooks may be issued to students when they leave their Chromebook for repair. If repair is needed due to malicious damage, the school may refuse to provide a loaner Chromebook. Students and Parent/Guardian/PIPR's s will be charged for Chromebook damage that is a result of misuse or abusive handling (see attached reimbursement sheet).

A student who transfers out of MCS will be required to return their Chromebook and accessories. If a Chromebook with accessories are not returned, the Parent/Guardian/PIPR's will be held responsible for payment in full.

Taking Care of Your Chromebook:

Students are responsible for the general care of their MCS issued Chromebooks. Chromebooks that are broken or fail to work properly must be taken to the Technology Office located in the upstairs computer room. If necessary, a loaner Chromebook will be issued during repairs.

General Precautions:

- No food or drink is allowed next to the Chromebook while it is in use.
- Cords, cables, and removable storage devices must be inserted carefully into the Chromebook.
- Students should never carry Chromebooks while the screen is open unless directed to do so by a teacher.
- Chromebooks should be shut down when not in use to conserve battery life.
- Chromebooks should never be shoved into a locker or wedged into a book bag. Doing so may break the screen.
- Do not expose the Chromebook to extreme temperature or direct sunlight for extended periods of time. Extreme heat or cold may cause damage to the laptop.
- Always bring the Chromebook to room temperature before turning it on.

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Carrying the Chromebook:

The protective shell of the Chromebook will only provide basic protection from everyday use. Please keep the Chromebook in the case provided. It is not designed to prevent damage from drops or abusive handling. Carrying the Chromebook in a padded backpack or padded book bag is acceptable provided the backpack or bookbag is handled with care. For example, do not toss the bag or drop the bag if the Chromebook is inside.

Screen Care:

The Chromebook screen can be damaged if subjected to rough treatment. The screens are particularly sensitive to damage from excessive pressure.

- Do not lean on top of the Chromebook.
- Do not place anything near the Chromebook that could put pressure on the screen.
- Do not place anything in the carrying case that will press against the cover.
- Do not poke the screen.
- Do not place anything on the keyboard before closing the lid (e.g. pens, pencils, notebooks).
- Clean the screen with a soft, dry anti-static, or micro-fiber cloth. Do not use window cleaner or any type of liquid or water on the Chromebook.

Using Your Chromebook

At School:

The Chromebook is intended for use at school each and every day. In addition to teacher expectations for Chromebook use, school messages, announcements, calendars, academic handbooks, student handbooks and schedules may be accessed using the Chromebook and the school's website. Students are responsible for bringing their Chromebook to all classes, unless specifically advised not to do so by their teacher.

At Home:

Some students may be required to take their Chromebook home each night throughout the school year for charging. Students need to charge their Chromebooks each evening. Chromebooks must be brought to school each day in a fully charged condition.

Students should not carry the AC adapter power cord to school. If fully charged at home, the battery will last throughout the day.

Sound:

Sound must be muted at all times unless permission is obtained from the teacher for instructional purposes.

Printing:

Printing from the Chromebook is not available.

Managing Files and Saving Work:

Students may save documents to their Google Drive, or they may save to an external memory device such as a miniSD card or USB flash drive. Saving to Google Drive will make the file accessible from any computer with internet access. Students using Google Drive will not need to save their work Google Drive will save each

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keystroke as the work is being completed. It will be the responsibility of students to maintain the integrity of their files and keep proper backups. Students will be trained on proper file management procedures.

Personalizing the Chromebook:

Chromebooks must remain free of any decorative writing, drawing, stickers, paint, tape, or labels that are not the property of Milford Central School. Spot checks for compliance will be done by administration or MCS Staff at any time.

Inspection:

Students may be selected at random to provide their Chromebook for inspection. The purpose for inspection will be to check for proper care and maintenance or for inappropriate material being carried into the school.

Procedure for Restoring the Chrome OS:

If technical difficulties occur the Chromebook will be restored to factory defaults.

Protecting & Storing The Chromebook:

Chromebook Identification:

Under no circumstances are students to modify, remove, or destroy identification labels.

Storing Chromebooks:

When students are not monitoring their Chromebooks, they should be stored in their lockers with the locks securely fastened. Nothing should be placed on top of the Chromebook when stored in the locker. Students are responsible for securely storing their Chromebooks during extra-curricular events. Under no circumstance should Chromebooks be stored in unsupervised areas. Unsupervised areas include the school grounds and campus, the cafeteria, unlocked classrooms, library, locker rooms, dressing rooms, hallways, bathrooms, extra-curricular bus, cars, or any other entity that is not securely locked or in which there is not supervision.

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Milford Central School District

STUDENT/Parent/Guardian/PIPR's CHROMEBOOK and Acceptable Use Policy SIGNATURE PAGE

Parents/Guardians/PIPRs and students must sign and return this form to the student's teacher or computer room staff. If this form is not signed by both parties and on file with the school, the student will be denied Internet and Network access and a Chromebook.

To Be Completed by Student:

- ☒ I have read the MCS District Chromebook Use Agreement. I agree to abide by the rules contained therein.
- ☒ I understand that use of the Internet and Network at MCSD is a privilege and I will abide by the MCSD Acceptable Use of Computers & Internet Policy (4526). I understand that I may only use the Internet and Network for educational purposes as directed by my teachers. I will not access inappropriate materials on the Internet. I understand that if I commit any violation of the policy, I will lose my access privileges and may be disciplined for my actions.
- ☒ The District and affiliated organizations (MEF/associated colleges) may post or publicize student work or photos on paper and their website and Milford school's official social media in accordance with the Family Educational Rights Act Policy that is available on the school's website.

Student's Name (please print): _____ Grade: _____

Student's Signature: _____

Date: _____

To Be Completed by all Parents/Guardians/PIPRs:

- ☒ I have read the MCS District Chromebook Use Agreement. I agree to the rules contained therein.
- ☒ I give permission for my child to participate in the use of the Internet and Network at MCSD. I realize that s/he will be able to access major networks throughout the world using the Internet. I understand that this access is designed and intended for educational purposes only.

I have read the MCS Acceptable Use of Computers & Internet Policy (4526) with my child. We agree to abide by the rules contained therein. I understand that MCS prohibits students from accessing inappropriate materials and will not hold MCSD accountable for unsuitable materials acquired by my child through Internet use at school.

- ☒ The District and affiliated organizations (MEF/associated colleges) may post or publicize student work or photos on paper and their website and Milford school's official social media in accordance with the Family Educational Rights Act Policy that is available on the school's website.

Child's Name (please print): _____ Grade: _____

Parent/Guardian/PIPR's Name (please print): _____

Parent/Guardian/PIPR's Signature: _____

Date: _____