OSWEGO
CITY SCHOOL DISTRICT
Fully prepared and life ready!

Education Center
120 East First Street, Oswego, New York 13126
www.oswego.org

New Student Registration Packet

Attached is student registration forms and information for enrolling your son/daughter in the Oswego City School District.

In addition to this paperwork, you will need to provide us with the following proof:

- ☐ Original Birth Certificate
- ☐ Immunization Records - Present New York State Laws require that no school official shall permit any child to be admitted to school or to attend school for more than 14 days without a certificate, or other acceptable written evidence, that the child has met NYS immunization requirements. Therefore, no child shall be allowed admission to school without providing proper proof of immunization either from the school previously attended or from the student.
- ☐ Custody Papers *(if applicable)*
- ☐ Proof of Residency

The New Student Enrollment packet contains the following:

- ☐ Registration Form
- ☐ Student Residency Questionnaire
- ☐ Oswego City School District Health History Survey
- ☐ School Physical Consent Form
- ☐ Health Certificate/Appraisal Form
- ☐ Dental Health Form
- ☐ Home Language Questionnaire
- ☐ Parent/Guardian Military Service Form

Proof of Immunization

- ☐ Waived-Rel./Dr. Stmt.
- ☐ Certificate of Immunization
- ☐ Statement - Dr./Hlth Ct.
- ☐ Shot Rec. from Transfer Sch.

☐ FPS ☐ CER ☐ OMS ☐ Trinity Cathlic
☐ KPS ☐ FLS ☐ OHS ☐ OCCS
☐ MIN

City School District of Oswego, Oswego, New York 13126

Registration Form

Date of Entry _____

Office Use Only

- ☐ Out of District
- ☐ Proof of Residency
- ☐ Re-Activated
- ☐ Transfer Within
- ☐ Rec. Rq. _____ Rec. _____

Student Data

Name _____ (Last) (First) (Middle)

Date of Birth _____ Type of Document _____ Gender/Sex _____ Grade _____

Physician's Name _____ Physician's Phone No. _____

Please answer questions 1 and 2:

1. Are you Hispanic/Latino? ☐ Yes ☐ No
2. Select one or more race groups that apply to your child. You must check (√) at least one box:
   ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black ☐ White

Parent/Guardian Data

Name _____ (Last) (First)

Residence _____ RD No.

_____ House No./ Box No. Road or Street No.

_____ City State Zip

Home Phone No. _____ Unlisted: ☐ Yes ☐ No

Cell Phone No. _____ email _____

Legal Relation to Child _____

Place of Employment _____

Address _____ Phone No. _____

Spouse's Name _____ (Last) (First)

Spouse's Residence _____ (Leave this blank if same as parent/guardian)

_____ House No./ Box No. Road or Street No.

_____ City State Zip

Home Phone No. _____ Unlisted: ☐ Yes ☐ No

Cell Phone No. _____ email _____

Legal Relation to Child _____

Spouse Place of Employment _____

Address _____ Phone No. _____

Names of other adults in the child's household: _____ (Last) (First) Relationship to the child: _____

Custody Information: If separated or divorced, who has legal custody? _____

Does this school have updated custody documentation on file? ☐ Yes ☐ No

Foster Student? ☐ Yes ☐ No DSS2999 Form? ☐ Yes ☐ No

Special Services

Does your child receive any special education services? ☐ Yes ☐ No

Emergency Contact Person Other Than Parent

Name _____ Relation to Child _____ Phone No. _____

Address _____ Cell Phone No. _____

Daycare's Name _____ Address _____ Cell/Phone No. _____

Names & Birthdates of Other Children That Live at Home

_____ _____

_____ _____

_____ _____

Last School Attended

Name _____

Address _____

Parent/Guardian Signature

Parent/Guardian Signature _____ Date _____

For Office Use Only

Pre-Kindergarten ☐ A.M. ☐ P.M. Student ID # _____ Family ID # _____

Lunch Program ☐ Free ☐ Reduced ☐ N/A Hmrm Teacher/Rm.# _____

Walker ☐ Yes ☐ No Bus Route # - To School _____ /From School _____ Pick-up/Drop-off Point _____

Enrollment Code _____

Copy Distribution - Student Academic Folder, Main Office , School Nurse, Transportation, Pupil Services

Continue form on back ⇩

Student Residency Questionnaire

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 box)*

- ☐ 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 "double-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

Office Use Only

Please send a copy to the Runaway Homeless Youth (RHY) Coordinator at Oswego High School.

If the student is **NOT** living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____

Runaway Homeless Youth Signature Date

For New Registrations, New Incoming Pre-Kindergarten and Kindergarten Children

Oswego City School District Health History Survey

Student Name _____ Date of Birth _____

Parent/Guardian Name _____ Home Phone _____ Work Phone _____

School _____ Date _____

Please answer each question by writing a check (√) in the appropriate box providing information requested.

	Yes	No
Did you submit a copy of your child's immunization records when you registered him/her	☐	☐
Has you child received a TB (tuberculosis) skin test?	☐	☐
Has any family member or relative under the age of 50?		
had a heart attack, stroke, or died unexpectedly	☐	☐
had high blood pressure	☐	☐
had learning disabilities	☐	☐
Other (please indicate below)	☐	☐
Has your child had the following illnesses?		
Chicken pox	☐	☐
Red or hard measles	☐	☐
German or three-day measles (rubella)	☐	☐
Other (please indicate below)	☐	☐
Does your child have any of the following health problems?		
Vision problems	☐	☐
If yes, what? _____		
Glasses or corrective lenses	☐	☐
Chronic ear infections	☐	☐
Tubes in ears	☐	☐
Hearing aids	☐	☐
Hearing loss	☐	☐
Other hearing problems	☐	☐
If yes, what? _____		
Allergies to:		
Medication, What kind _____		
Insects, What kind _____		
Food, What kind _____		
If yes, what reactions to expect? What medical procedures need to be taken? _____		
Asthma	☐	☐
Heart problems	☐	☐
If yes, what? _____		
Epilepsy	☐	☐
Hay fever	☐	☐
Diabetes	☐	☐
Hemophilia (free bleeding)	☐	☐
Rheumatic fever	☐	☐
Cystic fibrosis	☐	☐

	Yes	No
Muscular dystrophy	☐	☐
Cancer	☐	☐
Physical disabilities	☐	☐
If yes, what? _____		
Mental disabilities (for example, autism, developmental delay)	☐	☐
If yes, what? _____		
Attention deficit/hyperactivity disorder	☐	☐
Other health problems	☐	☐
If yes what? _____		
Has your child ever seen, or is your child currently seeing, a specialist (for example, cardiologist, neurologist)?	☐	☐
If yes, what? _____		
Has your child ever been hospitalized?	☐	☐
If yes, for what reason? _____		
Has your child ever had a serious accident (for example, broken bones, bad cuts, poisoning)?	☐	☐
If yes, what? _____		
Is your child on any medication?	☐	☐
If yes, what? _____		
Has your child been seen by a physician in the last year?	☐	☐
Has your child been seen by a dentist in the last year?	☐	☐

OVER ☛

Does your child now have, or has your child had in the last year, any of the following problems?	Yes, has now	Yes, in the last Year	No
Headaches	☐	☐	☐
Problems with eyes (for example,squinting, crusting lids, wandering eye)	☐	☐	☐
Chronic colds (more than 6 in one year, or a cold Lasting more than 3 weeks)	☐	☐	☐
Shortness of breath	☐	☐	☐
Severe cough	☐	☐	☐
Throat infection	☐	☐	☐
Ear infection	☐	☐	☐
Tooth pain, cavities, mouth sores	☐	☐	☐
Swollen glands or lumps	☐	☐	☐
Stomach aches	☐	☐	☐
Eating or drinking too much	☐	☐	☐
Eating or drinking too little	☐	☐	☐
Weak urinary system (frequent urination)	☐	☐	☐
Pain or burning upon urination	☐	☐	☐
Bed wetting	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Unusual diffculty standing or walking	☐	☐	☐
Trouble sleeping	☐	☐	☐
Tiring easily	☐	☐	☐
Joint pain	☐	☐	☐
Seizures, convulsions, or fits	☐	☐	☐
Bleeding problems (for example, bruising Easily, frequent nose bleeds)	☐	☐	☐
Other (please indicate below)	☐	☐	☐

_____

_____

_____

_____

Please answer the following questions about the pregnancy, labor, and delivery of your child:

	Yes	No
Did the mother have difficulties during the pregnancy, labor, or delivery of your child?	☐	☐
If yes, what? _____		
Did the mother visit a physician or medical clinic during her pregnancy?	☐	☐
Was your child born at home or at any place other than a hospital or medical clinic?	☐	☐
If yes, where? _____		
Did your child have difficulties at birth or shortly after (for example, jaundice (yellow skin), breathing problems, infection, high fever, feeding problems)?	☐	☐
If yes, where? _____		
Did your child weigh less than 5½ pounds at birth?	☐	☐
If yes, how much did the child weigh?		
Was your child born prematurely?	☐	☐
If yes, by how many weeks? _____		
Was your child born post-maturely?	☐	☐
If yes, by how many weeks? _____		
Was your child placed in a neonatal intensive Care nursery or high-rish nursery after birth?	☐	☐
If yes, for how many days? _____		

Please check to make sure you have answered every item. Then, write in the space below any additional comments you have about your child's health history.

Name of Family Physician _____ Phone _____

Name of Family Dentist _____ Phone _____

Date _____

Signature of Parent/Guardian _____

Comments:

_____

_____

_____

_____

_____

_____

OSWEGO
CITY SCHOOL DISTRICT
Fully prepared and life ready!

Education Center
120 East First Street, Oswego, New York 13126
www.oswego.org

School Physical Consent Form

Student Name:_____ Grade:_____

School:_____ DOB:_____

Please read and check the correct box. Sign and return to the school nurse.

☐ I do give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws.

☐ I do not give permission for the designated school physician or nurse practitioner to complete a physical examination as per school policy and as required by NYS Education Laws. I will have a physical completed by our family physician.

This consent is valid from this date unless revoked by the parent or guardian. If custody or guardianship changes in the future, it is the responsibility of the parent or guardian to notify the school district of such a change.

_____ _____

Signature of Parent or Legal Guardian Date

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

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

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

I give permission for the exam to be done in school: Parent Signature: _____ Date: _____

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: _____

Body Mass Index: ___ ___ . ___
Weight Status Category (BMI Percentile):
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher

		Referral
Vision - without glasses/contact lenses	R _____	L _____
Vision - with glasses/contact lenses	R _____	L _____
Vision - Near Point	R _____	L _____
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
Note: Nurse will also assess self-direction for the school setting.

Student may self carry and self administer medication ❑ Yes ❑ No
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: cheer leading, 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: _____

This exam complies with NTSED requirements above and is valid for twelve months, with the exception of illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director Rev 02/08

Dental Health Certificate - Optional

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: (Month / Day / Year) / /

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 *(please print or stamp)*

Dentist'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 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.

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

Lissette Colon-Collins, Assistant 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 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 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.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother	*specify*	❑ Father	*specify*
	❑ Guardian(s)	*specify*		
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other	*specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other	*specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other	*specify*	❑ Does not write

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

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ❑ Mother ❑ Father ❑ 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

OSWEGO
CITY SCHOOL DISTRICT
Fully prepared and life ready!

Education Center
120 East First Street, Oswego, New York 13126
www.oswego.org

Impact Aid Registration Form

Military Service

(Additional data required of Parent/Guardian with present military service)

Name of Student _____ Date of Birth _____

School Enrolled In:_____ Grade_____

Home Address _____

Name of parent/guardian (A) _____

Relationship to student _____

Federal property on which parent/guardian (A) is employed _____

Name of firm, agency or uniformed services branch employing parent/guardian (A) _____

Name of parent/guardian (B) _____

Relationship to student _____

Federal property on which parent/guardian (B) is employed _____

Name of firm, agency or uniformed services branch employing parent/guardian (B) _____

If either parent is the uniformed services, please indicate:

Name of Parent _____ Rank/Unit_____

_____ _____

Signature of Parent/Guardian Date

Oswego City School District Transportation Department

Date: _____

AM - Stop Location: _____ Bus #: _____
PM - Stop Location: _____ Bus #: _____

2016-17 Transportation Department Bus Registration / Student Information Update Form

The following information is needed to assist us in assigning your child to a school bus route. This form must be completed prior to assigning new students to a bus, or changes are made for students currently assigned. The transportation office will assign students to the closest available stop upon receipt of this form. If a stop is more than .5 miles from home or if the walk route to the stop appears unsafe, a bus stop change request can be submitted. All specialized transportation needs as determined by the IEP team will be sent on the Special Needs Transportation Form. If you have any questions please contact the transportation office at (315) 341-2900.

****Note: Parent or guardian must be at the bus stop morning and afternoon for Pre-K and Kindergarten. Students will be returned to school if the adult is not at the bus stop. Parents/guardians are responsible for the supervision of students as they travel to and from bus stops and while they wait for buses to arrive.**

Check appropriate option. Information is for new student ( ) Update for current student ( )

Student Name: Legal Name: _____ Nick Name: _____

Date of Birth: _____ School: _____ Grade: _____ Teacher: _____

Parent or Guardian: _____ E-mail Address: _____

Phone: Home: _____ Work: _____ Cell/Mobile: _____

Address: _____ City: _____ Zip Code_____

Subdivision: _____ Cross Streets: _____ Directions to your home from zoned school: _____

Photograph Release: (during bus training or other bus related situations)

I hereby release the Oswego City School District and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my child's participation:

- o I agree to release of my child's photograph
- o I do not agree to release of my child's photograph

Emergency medical information (list any health concerns or medication the driver should be aware in case of an emergency.)

List family members or other emergency contact authorized to pick up your child if you are not available. <u>Picture ID will be required at the bus stop</u> (use back of page if needed):

_____ Phone: _____ Relationship: _____
_____ Phone: _____ Relationship: _____
_____ Phone: _____ Relationship: _____

Can this student participate in any food-based treats/rewards? YES No
If yes, please list all food allergies _____

Parent Signature: _____

FOR OFFICE USE ONLY

Route #:_____ Stop Location: _____ Time: AM_____ PM _____
Parent Notified On: _____ Driver Notified On: _____ School Notified On: _____
Data entered by: _____ Route Color _____ Date completed: _____