**CHESTER UNION FREE SCHOOL DISTRICT**
**REGISTRATION PACKET COVER SHEET**

**PROOF OF RESIDENCY (One document from Group A and three documents from Group B – except if in temporary shelter). All documents must show your name and Chester address.**
**P.O. Box addresses <u>are not accepted</u> as proof of residency.**

**A.**
- ☐ Deed to property
- ☐ Temporary shelter proof
- ☐ Mortgage agreement
- ☐ Residential Lease with current rent receipt
- ☐ A statement from a Landlord or Owner concerning your tenancy
- ☐ A sworn notarized statements from a third party that establishes your presence in the Chester Union Free School district and if you are or are not paying rent. (Affidavits #1 and 2 – see registrar) (The landlord needs to provide proof of residency in the district, also, from the list below)

**SUPPLEMENTARY PROOF OF RESIDENCY** – You may submit any other relevant evidence you wish to, including but not limited to the following types of documentation with the location of service indicated and/or current street address to indicate residency.

**B.**
- ☐ Tax bill
- ☐ Bank statement
- ☐ Electric and gas bill
- ☐ Current Payroll stub
- ☐ Telephone bill
- ☐ Medicaid forms
- ☐ Cell phone bill
- ☐ Driver's license or Non-Driver ID with address
- ☐ Cable bill
- ☐ Vehicle registration
- ☐ Insurance policy and/or bill
- ☐ IRS tax return
- ☐ Voter registration card
- ☐ Moving company delivery receipt
- ☐ Official Postal Address Change Form
- ☐ Documents issued by federal, state or local agencies
- ☐ Health care benefits statement
- ☐ Other _____

**PROOF OF AGE (One of the following)**

- ☐ Original or Certified Transcription of your child's Birth certificate regardless of issuing nation
- ☐ Original or Certified Transcription of your child's Baptismal Certificate regardless of the issuing nation

If you are unable to provide either of the above documents:

- ☐ Your child's Passport regardless of the issuing nations

**In the absence of the above documents, you may provide any other documentation that has been in existence for over two years that could be used to establish your child's age. For example:**

- ☐ Official driver's license or non-driver ID card
- ☐ State or local government issued identification
- ☐ Military dependent ID card
- ☐ School photo identification with date of birth
- ☐ Consulate identification records
- ☐ Hospital or health records
- ☐ Documents issued by federal, state or local agencies
- ☐ Court orders or other court issued documents
- ☐ Native American tribunal document
- ☐ Records from non-profit international aid agencies and voluntary agencies

**PROOF OF CUSTODY, GUARDIANSHIP OR FOSTER CARE**

☐ If parents are separated, divorced or have a custody order, these documents must be provided to the District. If foster parents, documents from NYS Office of Children and Family Services (e.g., LDSS-2999)

☐ If custody/guardianship is with a third party, you must complete and submit Affidavits of Responsibility (Parent and Custodial Person). The District will consider requests for exceptions to this requirement in limited but appropriate circumstances.

☐ Government issued Picture ID of the Parent/Guardian

**HEALTH RECORDS** _____

(Including Immunization Records and Physical Examination within 12 months of start of school year)

**SCHOOL RECORD/REPORT CARD** _____

(If a student is coming from another school district, you must ask if either of the documents below is applicable to this student.)

**CUSTODY PAPERS (If applicable)** _____ **6. IEP (Spec Ed only)** _____

In order to make a timely decision regarding a student's right to enrollment or continued enrollment in the District, the above information and documentation should be delivered to the Registrar tomorrow (or the next regular business day if tomorrow is a weekend or holiday).

**REGISTRAR**: Put your initials on the line next to each document that you collect from the parent/legal guardian above. Once the packet is complete, attach this cover sheet to the packet and give to the building principal for verification.

**PRINCIPAL**: Building principal will initial "custody papers" above if applicable. The Director of Special Education will initial "IEP" if applicable. Only the building principal can sign the verification below once all paperwork has been received and reviewed.

_____ _____

**Building Principal's Signature** **Date**

CHESTER UNION FREE SCHOOL DISTRICT
64 HAMBLETONIAN AVENUE
CHESTER, NEW YORK 10918

# REQUEST FOR RECORDS FORM

**DATE:** _____

**PREVIOUS SCHOOL'S NAME, ADDRESS & PHONE #:** **STUDENT'S NAME**: _____

_____

_____

_____

The above-named student enrolled on _____ in our district and will be entering _____ grade.
Please send us, as soon as possible, the following information:

- Scholastic Record (final grades or grades to date of present year; explanation of marking system)
- Standardized Test Results
  (Aptitude & achievement; New York schools should include RCT results, screening survey, NYSESLAT/NYSITELL results)
- Attendance Records
- Health Records
- Discipline Records
- Psychological Reports, if any
- Family data, other pertinent data
- Indicate whether this student is in need of any special psychological
- Medical or Education Services YES ☐ NO ☐

**********

**SPECIAL EDUCATION RECORDS**

Please forward all CSE records (if any) on above-named student to:

Director of Special Education
Chester Union Free School District
64 Hambletonian Avenue
Chester, New York 10918

- Current IEP
- Psychological records and evaluations
- Academic reports
- Achievement testing

Speech
OT
PT
Counseling

We would be pleased to receive any further information which you feel would be of importance to this office.

**********

**PARENTAL AUTHORIZATION TO SEND RECORDS – Please check the school your child will be attending:**

I hereby authorize you to send all school records on my child named above to:

☐ **Chester Academy**
64 Hambletonian Avenue
Chester, New York 10918
Phone: (845) 469-2231 x3302
FAX: (845) 469-3606
Email: patty.goodrich@chesterufsd.org

☐ **Chester Elementary School**
2 Herbert Drive
Chester, New York 10918
Phone: (845) 469-2178 x2202
FAX: (845) 469-2794
Email: lindsay.iannuzzi@chesterufsd.org

_____
**Parent/Guardian Signature**

# CHESTER UNION FREE SCHOOL DISTRICT
# NEW STUDENT REGISTRATION FORM

☐ ELEMENTARY SCHOOL ☐ CHESTER ACADEMY

STUDENT NAME _____ ☐ Male ☐ Female ☐ Non-Binary GRADE _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET PO BOX (IF ANY) TOWN STATE ZIP

TELEPHONE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____
**(IF UNLISTED, PLEASE SPECIFY)**

DATE OF ENTRY INTO GRADE 9 _____

**Check** if the student is of Hispanic or Latino Origin? Yes, Hispanic ☐ No, Non-Hispanic ☐

**Check the race of the student**: American Indian or Alaskan Native ☐ Asian ☐
Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White (Caucasian) ☐

**Please place language number in appropriate box below:**

☐ DOMINANT LANGUAGE SPOKEN IN HOME ☐ LANGUAGE IN WHICH STUDENT IS FLUENT

1. ENGLISH 2. SPANISH 3. ITALIAN 4. FRENCH 5. FRENCH/CREOLE 6. CHINESE 7. GREEK
8. YIDDISH 9. HEBREW 10. RUSSIAN 11. GERMAN 12. ARABIC 13. POLISH 14. OTHER _____

**Any Academic Special Needs or Considerations**: _____

FATHER'S NAME _____ MOTHER'S NAME _____

DATE OF BIRTH _____ DATE OF BIRTH _____

PLACE OF BIRTH _____ PLACE OF BIRTH _____

OCCUPATION _____ OCCUPATION _____

COMPANY NAME _____ COMPANY NAME _____

ADDRESS _____ ADDRESS _____

TELEPHONE _____ TELEPHONE _____

STEP-PARENT/GUARDIAN NAME & PHONE _____

**SIBLINGS**:

| NAME | DATE OF BIRTH | GRADE IN SCHOOL | RESIDENCE, IF AWAY FROM HOME | REMARKS Male/Female |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**CHESTER UNION FREE SCHOOL DISTRICT**
**RESIDENCY QUESTIONNAIRE**

Name of LEA: CHESTER UNION FREE SCHOOL DISTRICT

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female ☐ Non-Binary

Date of Birth: ____ /____ /____ (*Month Day Year*)

Grade: ____ (*preschool-12*)

ID#: _____ (*optional*)

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, proof of age, school records, or immunization records. 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 "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*

If **ANY box other than "In Permanent Housing" is checked,** , then the student/family should be immediately referred to the McKenney-Vento (MV) Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's MV liaison must help the student get any other necessary documents or immunizations.



cc: Transportation
Data Administrador

**CHESTER UNION FREE SCHOOL DISTRICT**
**CUESTIONARIO DE VIVIENDA**

Nombre del Distrito Escolar: CHESTER UNION FREE SCHOOL DISTRICT

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer ☐ No-Binario Fecha de Nacimiento: _____ / _____ / _____ Grado:_____ ID#: _____
*Mes Día Año (jardín de infantes – 12) (opciónal)*

Dirección: _____ Teléfono: _____

**Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar.**

**¿Dónde está el estudiante viviendo actualmente?** (*Por favor marque **una** caja.*)

☐ En un refugio
☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
☐ En un hotel/motel
☐ En un carro, parque, autobús, tren, o camping
☐ Otra vivienda temporal (Por favor describa):
_____

☐ En un hogar permanente

_____ _____
**Nombre** de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

**Firma** de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____
**Fecha**

Si CUALQUIER caja que no sea "En un hogar permanente" está marcada, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente**. Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.



cc: Transportación
Data Administrador

**CHESTER UNION FREE SCHOOL DISTRICT**

# STUDENT EMERGENCY FORM

Student's Name_____
Last First Birthdate **Grade**

Home Address _____ Phone _____

_____
**Parent/Guardian (primary contact)** Home Address (if different) Parent Email

_____
Place of Employment Work Phone Cell Phone

_____
**Parent/Guardian (second contact)** Home Address (if different) Parent Email

_____
Place of Employment Work Phone Cell Phone

**If my child has to be taken home because of a minor illness and I am not there or cannot be reached, please call:**

_____
**Name of 1st contact** Address cell phone / home phone

_____
**Name of 2nd contact** Address cell phone / home phone

_____
**Name of 3rd contact** Address cell phone / home phone

Doctor: _____Address_____Phone_____

Dentist: _____Address_____Phone_____

My child has the following conditions which requires special handling in any emergency:_____

_____

Are there any individuals whose access to your child is prohibited or restricted by court order? _____
(If yes, please attach copies of court order)

In an emergency, when you cannot reach one of the above, I authorize the school to call 911 or the physician listed above. This authorization also includes permission to release pertinent medical records needed. In the event that one of the parents/guardians cannot be reached, please take my child to the nearest emergency treatment facility, by ambulance if necessary. I realize the school district cannot assume responsibility for the payment of medical fees or expenses incurred.

**Signature of parent/legal guardian** _____ Date_____

**PLEASE NOTIFY THE HEALTH OFFICE IF THERE ARE ANY HEALTH CONCERNS OR CHANGES DURING THE SCHOOL YEAR**

CC: Health Office
Main Office
Superintendent's Office

CHESTER UNION FREE SCHOOL DISTRICT
HEALTH OFFICE

**Chester Elementary School**
**2 Herbert Drive**
**Chester, NY 10918**
**845-469-2178 x2209**
**Fax: 845-469-2170**

**Chester Academy**
**64 Hambletonian Avenue**
**Chester, NY 10918**
**845-469-2231 x3315**
**Fax: 845-469-6634**

Child's Name: _____Date & Place of Birth: _____

Child's Address: _____Child's Home Phone #: _____

Parent/Guardian's Name: _____Relationship: _____

Resides with: (Y/N) Cell #: _____ Work #:_____

Parent/Guardian's Name: _____Relationship:_____

Resides with: (Y/N) Cell #: _____ Work #:_____

Please indicate if your child has been treated for any of the following diseases/conditions:

- ☐ Asthma
- ☐ Chicken Pox Date: _____
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Bone fracture(s)
- ☐ Seizures
- ☐ Frequent sore throats
- ☐ Frequent earaches
- ☐ Mononucleosis
- ☐ Scarlet Fever
- ☐ Heart Disease

Other _____

Has your child been hospitalized for any serious illness or injury? : _____ if yes, please list:_____

Does your child take medication regularly? _____ Name of Medication _____

Does your child have any allergies? _____ If yes, please list those allergies:_____

_____

Has your child received medical treatment for any allergic reaction? _____ if yes, please list:_____

Does your child have any medical condition that could require immediate FIRST AID? _____

If yes, please describe: _____

Are there any special services that your child requires that the school should be made aware of? _____

_____

Does your child wear glasses? _____ Date of last eye exam: _____

Signature: _____Date: _____

**CHESTER UNION FREE SCHOOL DISTRICT**
**HEALTH OFFICE**

**Chester Elementary School**
**2 Herbert Drive**
**Chester, NY 10918**
**(845) 469-2178 x2209**
**Fax: (845) 469-2170**

**Chester Academy**
**64 Hambletonian Avenue**
**Chester, NY 10918**
**(845) 469-2231 x3315**
**Fax: (845) 469-6634**

Physical exams must be performed within the 12 months prior to the beginning of the school year in which the examination is required or within 15 days after registration in order to be acceptable. If you choose to have your child examined by your health care provider, please submit the completed medical form to the school health office by **September 30th**. If not received by this date, your child will be scheduled for a physical with the school nurse practitioner.

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or 'BMI'. The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to New York State Department of Health information about our students' weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report. Please visit the district website to access the optional opt-out form.

Annual vision, hearing and scoliosis screenings will be performed according to the New York State guidelines.

If your child will need to take medication in school, please have your child's health care provider complete the Medication in School form which can be found on the Health Office Web page on the district website.

---

COMPLETE AND RETURN THIS SECTION:

_____ I will have my child examined by my own health care provider.
_____ The examination has been scheduled for the following date: ___/___/___
_____ I would like my child to be examined in school by the nurse practitioner.

Child's name _____ Grade _____

Parent/Guardian's Signature _____ Date _____

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**
**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

| | | |
|---|---|---|
| Name: | Sex: ☐M ☐F | DOB: |
| School: | Grade: | Exam Date: |

**HEALTH HISTORY**

| | | |
|---|---|---|
| **Allergies** ☐ **No** ☐ Yes, indicate type | ☐ Medication/Treatment Order Attached | ☐ Aaphylaxis Care Plan Attached |
| ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental | | |
| **Asthma** ☐ **No** ☐ Yes, indicate type | ☐ Medication/Treatment Order Attached | ☐ Asthma Care Plan Attached |
| ☐ Intermittent ☐ Persistent ☐ Other : _____ | | |
| **Seizures** ☐ **No** | ☐ Medication/Treatment Order Attached | ☐ Seizure Care Plan Attached |
| ☐ Yes, indicate type | ☐ Type: _____ | Date of last seizure: _____ |
| **Diabetes** ☐ **No** | ☐ Medication/Treatment Order Attached | ☐ Diabetes Medical Mgmt. Plan Attached |
| ☐ Yes, indicate type | ☐ Type 1 ☐ Type 2 | ☐ HgbA1c results: _____ Date Drawn: _____ |

**Risk Factors for Diabetes or Pre-Diabetes:**
*Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.*

**BMI**_____kg/m2 **Percentile (Weight Status Category):** ☐<5th ☐5th-49th ☐50th-84th ☐85th-94th ☐95th-98th ☐99th and<

| | |
|---|---|
| **Hyperlipidemia:** ☐ No ☐ Yes | **Hypertension:** ☐ No ☐ Yes |

**PHYSICAL EXAMINATION/ASSESSMENT**

| **Height:** | **Weight:** | BP: | **Pulse:** | **Respirations:** |
|---|---|---|---|---|
| **TESTS** | **Positive** | **Negative** | **Date** | **Other Pertinent Medical Concerns** |
| PPD/ PRN | ☐ | ☐ | | One Functioning: ☐ Eye ☐ Kidney ☐ Testicle |
| Sickle Cell Screen/PRN | ☐ | ☐ | | ☐ Concussion – Last Occurrence: _____ |
| **Lead Level Required Grades Pre- K & K** | **Date** | | | ☐ Mental Health: _____ ☐ Other: |

☐ Test Done ☐ Lead Elevated > 10 µg/dL

☐ **System Review and Exam Entirely Normal**

**Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ Musculoskeletal |

| | |
|---|---|
| ☐ Assessment/Abnormalities Noted/Recommendations: | Diagnoses/Problems (list) ICD-10 Code<br>_____ _____<br>_____ _____<br>_____ _____ |

| | | | | |
|---|---|---|---|---|
| Name: | | | DOB: | |
| **SCREENINGS** | | | | |
| **Vision** | **Right** | **Left** | **Referral** | **Notes** |
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No | |
| Distance Acuity With Lenses | 20/ | 20/ | | |
| Vision – Near Vision | 20/ | 20/ | | |
| Vision – Color ☐ Pass ☐ Fail | | | | |
| **Hearing** | **Right** dB | **Left** dB | **Referral** | |
| Pure Tone Screening | | ☐ Yes ☐ No | | |
| **Scoliosis** Required for boys grade 9 | **Negative** | **Positive** | **Referral** | |
| And girls grades 5 & 7 | ☐ | ☐ | ☐ Yes ☐ No | |
| Deviation Degree: | | Trunk Rotation Angle: | | |
| **Recommendations:** | | | | |
| **RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK** | | | | |
| ☐ **Full Activity** without restrictions including Physical Education and Athletics. | | | | |
| ☐ **Restrictions/Adaptations** | | Use the Interscholastic Sports Categories (below) for Restrictions or modifications | | |
| ☐ No Contact Sports | | **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling | | |
| ☐ **No Non-Contact Sports** | | **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field | | |
| ☐ **Other Restrictions:** | | | | |
| ☐ **Developmental Stage for Athletic Placement Process ONLY** | | | | |
| Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports<br>Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V | | | | |
| ☐ **Accommodations:** Use additional space below to explain | | | | |
| ☐ Brace*/Orthotic | ☐ Colostomy Appliance* | ☐ Hearing Aids | | |
| ☐ Insulin Pump/Insulin Sensor* | ☐ Medical/Prosthetic Device* | ☐ Pacemaker/Defibrillator* | | |
| ☐ Protective Equipment | ☐ Sport Safety Goggles | ☐ Other: | | |
| *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions. | | | | |
| Explain: _____ | | | | |
| **MEDICATIONS** | | | | |
| ☐ **Order Form for Medication(s) Needed at School attached** | | | | |
| List medications taken at home: | | | | |
| **IMMUNIZATIONS** | | | | |
| ☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No | | | | |
| **HEALTH CARE PROVIDER** | | | | |
| Medical Provider Signature: | | **Date:** | | |
| Provider Name: *(please print)* | | Stamp: | | |
| Provider Address: | | | | |
| Phone: | | | | |
| Fax: | | | | |
| **Please Return This Form To Your Child's School When Entirely Completed.** | | | | |

**CHESTER UNION FREE SCHOOL DISTRICT**
**HEALTH OFFICE**

**Chester Elementary School**
**2 Herbert Drive**
**Chester, New York 10918**
**(845) 469-2178 x2209**
**Fax: (845) 469-2170**

**Chester Academy**
**64 Hambletonian Ave**
**Chester, New York 10918**
**(845) 469-2231 x3315**
**Fax: (845) 469-6634**

## Dental Referral

Beginning July 1, 2018, New York State Law requests that students enrolling in pre-kindergarten, kindergarten, 1st, 3rd, 5th, 7th, 9th and 11th grades in a public elementary school in this state to present a dental health certificate; such dental health certificate must contain a report of a comprehensive dental examination performed on such child.

**Name**_____**D.O.B**_____

**Grade** _____**Teacher**_____

**Dear Parents: Students should have an examination and cleaning by your dentist every 6 months to prevent serious tooth decay. Please take this form to your dentist for completion, and return it to the health office.**

**Dear Dentist**: After examining this student, please check off one of the following:

_____ ☐ Currently receiving dental services

_____ ☐ Dental work is completed

_____ ☐ No treatment required at this time

_____ ☐ Return for cleaning/check-up every_____months

**Other Recommendations:**

_____Date_____
**Signature of DDS/DMD/RDH**

Printed or stamped name_____

Address_____

Telephone_____Fax_____

**GRADE_____**

# CHESTER UNION FREE SCHOOL DISTRICT

## Acknowledgement of Computer/Internet and Code of Conduct Policies

1. Student Use of Computerized Information Resources (Acceptable Use) Policy Acknowledgement
2. 2022-2023 Chester Union Free School District Code of Conduct and Student Handbook Acknowledgement

## Student Initials:

_____ 1. I have received the Chester Union Free School District's **Student Use of Computerized Information Resources (Acceptable Use) Policy** and agree to abide by the terms and conditions contained in them. I further understand that violation of the policy and regulations is unethical and may constitute a criminal offense. Should I commit any violation my access privileges may be suspended or revoked and school disciplinary action and/or appropriate legal action may be taken.

_____ 2. I have received the ***2022-2023 Chester Union Free School District Code of Conduct and Student Handbook*** and agree to abide by the terms and conditions contained in them. Should I commit any violation school disciplinary action and/or appropriate legal action may be taken.

---

## Parent/Guardian Initials:

_____ 1. As parent / guardian of this student I have received and read the District's **Student Use of Computerized Information Resources (Acceptable Use) Policy.** I understand that this access is designed for educational purposes. However, I also recognize it is impossible for the Chester Union Free School District to restrict access to all controversial materials and will not hold them responsible for the materials acquired on the network. In consideration for the privilege of using the District's computer network and in consideration for having access to public networks, I hereby release the District, its operators and any institutions with which they are affiliated from any and all claims and damages of any nature arising from my child's use, or inability to use, the network and for Internet. I hereby give my permission for my child to access the Internet and certify that the information contained on this form is correct.

_____ 2. I have received the ***2022-2023 Chester Union Free School District Code of Conduct and Student Handbook*** and agree to abide by the terms and conditions contained in them. Should my child commit any violation school disciplinary action and/or appropriate legal action may be taken.

***By signing below I confirm I have read the above information and initialed each paragraph as it pertains to me.***

| **PARENT / GUARDIAN** | | |
|---|---|---|
| | | |
| **Print First Name** | **Print Last Name** | **Signature** |
| **STUDENT** | | |
| | | |
| **Print First Name** | **Print Last Name** | **Signature** |

**CHESTER UNION FREE SCHOOL DISTRICT**
**TRANSPORTATION REQUEST FORM**
**Please Print**

Date_____

STUDENT'S NAME____ _____
LAST FIRST

GRADE_____

PARENT'S NAMES: Father_____
LAST FIRST

Mother_____
LAST FIRST

**OR:**

PERSON STUDENT IS RESIDING WITH (**if different from Parents**) _____

RELATIONSHIP_____

TELEPHONE NUMBER_____EMERGENCY NUMBER_____

**ADDRESS** FOR BUS PICK UP AND DROP OFF (**No P.O. Boxes**)

_____
**Street** **City** **State** **Zip Code**

ADDRESS USED FOR BUS PICK UP AND DROP OFF, **IF DIFFERENT THAN ABOVE**:

a.m. _____

p.m. _____

PLEASE CHECK WHICH SCHOOL YOUR STUDENT ATTENDS:

_____☐_____ Chester Elementary _____☐_____ Chester Academy

X_____
SIGNATURE OF PARENT OR GUARDIAN

(FOR TRANSPORTATION USE ONLY)

STUDENT I.D._____ START DATE_____

a.m. Bus No._____ Stop_____

p.m. Bus No._____ Stop_____

Date forwarded to First Student Bus Company_____

Original: Transportation 1/21

## Chester UFSD -Parent Portal Registration Form

Report Cards and Progress Reports for the Chester School District are not mailed home. All such reports will be accessed through the Parent Portal. This effort helps us to "go green." **Please return this form to the Main Office of your child's school.** Please list your child/children who are enrolled in school. Once your child/children are in the school system, you will be receiving an email from Schooltools with a password to get into your school account.

Name_____ Grade_____

Name_____ Grade_____

Name_____ Grade_____

Name_____ Grade_____

Name_____ Grade_____

Name_____ Grade_____

Name of primary parent/guardian requesting e-mail communication:

_____

*E-mail address: _____

Address: _____

Phone: _____

(If more than one parent wants access to this communication, a second e-mail address should be included.)

Name of second parent/guardian requesting e-mail communication:

_____

*E-mail address: _____

Your signature below confirms your desire for electronic communication on issues relating to your child/children **(Required).**

**Please Sign**: _____

**Date**: _____