

Solvay Union Free School District Housing Questionnaire

Name of School: ☐ SES ☐ SMS ☐ SHS

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ / ____ / ____ Grade: ____ ID#: ____
Month Day Year (preschool-12) (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, 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 permanent housing

☐ 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): _____

Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date

NOTE: If ANY box other than "In Permanent Housing" is checked, then the student/family should be immediately referred to the McKinney-Vento Liaison.



SOLVAY UNION FREE SCHOOL DISTRICT

Mailing Address: P.O. Box 980 · Syracuse, NY 13209 · (315) 468-1111
Physical Address: 299 Bury Drive · Syracuse, NY 13209

Jay Tinklepaugh
Superintendent of Schools

**UPON COMPLETION OF THE PACKET, PLEASE CALL 315-484-1401 (ERIN BURNS @ SHS) OR
315-487-7061 (GINA DIFLORIO @ SMS)
OR 315-488-5422 (STORMIE BLIGH @ SES) TO DETERMINE THE NEXT STEPS.**

RESIDENCY AND AGE DETERMINATION

PLEASE NOTE: RESIDENCY DETERMINATION WILL BE MADE WITHIN THREE (3) BUSINESS DAYS OF THE INITIAL ENROLLMENT.

PROOF OF RESIDENCY:

**Please submit evidence establishing you and your child's physical presence in the school district.
Such evidence may include:**

- A copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statement;
- A statement by a third-party landlord, owner or tenant from whom the parent(s) or person(s) in parental relation leases or with whom they share property within the District, which may be either sworn or unsworn; or
- Such other statement by a third party establishing the parent(s)' or person(s) in parental relation's physical presence in the district.

If the documents described above are not available, the District will consider other documentation, including but not limited to:

- Pay stub;
- Income tax form;
- Utility or other bills;
- Membership documents i.e., library card(s) based upon residency;
- Voter registration documents(s);
- Official driver's license, learner's permit or non-driver identification;
- State or other government issued identification;
- Documents issued by federal, state or local agencies (i.e., local social service agency, federal Office of Refugee Resettlement); or
- Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers.

AGE DETERMINATION:

The District will require documentation and/or information establishing your child's age.

- In accordance with the Education Law § 3218, where a certified transcript of a birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of Baptism) giving the date of birth is available, no other form of evidence may be used to determine a child's age; or
- If a certified transcript of a birth certificate or record of baptism is not available, a Passport may be used.

If the documents described above are not available, the District will consider other documentation in existence for at least two years, including but not limited to:

- Official driver's license;
- State or other government issued identification;
- School photo identification with date of birth;
- Consulate identification card;
- Hospital or health records;
- Military dependent identification card,
- Documents issued by federal, state or local agencies (i.e., local social services agency, federal, Office of Refugee Resettlement);
- Court orders or other court-issued documents;
- Native American tribal document; or
- Records from non-profit international aid agencies and voluntary agencies.

ADDITIONAL DOCUMENTS FOR STUDENT PLACEMENT/SERVICES:

- Most recent report card
- IEP/504 Plan (if applicable)
- Transcript of grades (if available)
- Custody Documents (if applicable)

EVIDENCE OF IMMUNIZATIONS & PHYSICAL:

In accordance with New York State's Public Health Law, the District must also receive evidence that your child has been immunized in accordance with the New York State Department of Health Immunization Bureau's Immunization Requirements for School Entrance/Attendance. These records will be necessary to ensure your child's continued attendance. Additionally, please provide us with the records of any recent physical examination your child has received. New York State mandates that each new student entering a public school is required to have a physical examination upon entering the District. A physical completed no more than twelve months before the first day of the school year in question will meet this requirement.

When you have completed the registration packet and have the required documents, please call 315-484-1401 (Erin @ SHS) or 315-487-7061 (Gina @ SMS) or 315-488-5422 (Stormie @ SES) to determine the next steps.

Thank you.

Sincerely,
Jay Tinklepaugh
Superintendent of Schools

SOLVAY UNION FREE SCHOOL DISTRICT STUDENT REGISTRATION

Student ID#:		SES <input type="checkbox"/>	Grade Entering:	Teacher/Homeroom #:
Date Registered:	School:	SMS <input type="checkbox"/> SHS <input type="checkbox"/>	Proof of Residency Primary <input type="checkbox"/> Secondary <input type="checkbox"/>	Records Release Sent <input type="checkbox"/> Date: _____
Start Date:	Age Determination Form: _____ <input type="checkbox"/>		IEP/504 Plan <input type="checkbox"/>	Acceptable Use Form <input type="checkbox"/>
Transportation Form <input type="checkbox"/>	Immunization Record <input type="checkbox"/>		Free/Reduced Lunch App <input type="checkbox"/>	
<i>Do not write above this line – office use only</i>				

STUDENT'S NAME: _____ ☐ MALE ☐ FEMALE

Last First Full Middle Name

ADDRESS: _____

Number Street or Road Apt. # City Zip Code

DATE OF BIRTH: _____

CHILD RESIDES WITH: ☐ Father ☐ Mother ☐ Both Parents ☐ Other/Relationship _____

CHILD'S PARENTS ARE: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

WHO HAS CUSTODY? ☐ Father ☐ Mother ☐ Mother & Father Jointly ☐ Other/Relationship _____

☐ Foster Placement (*DSS-2999 must be provided*)

FAMILY STATUS

Living in household with student ☐ Yes ☐ No

Name		<input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Stepmother <input type="checkbox"/> Other/Relationship _____	
Home Address				
Employer Name				
Email				
Telephone Number in the order in which you prefer to be called	Classification?	Accept Text?	Unlisted?	Call for Attendance?
1 st	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 nd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 rd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Solvay Union Free School District has my permission to share educational records with this person.				<input type="checkbox"/> Yes <input type="checkbox"/> No

SOLVAY UNION FREE SCHOOL DISTRICT STUDENT REGISTRATION (Page 2)

Student Name: _____

FAMILY STATUS				
Living in household with student <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name		<input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Stepfather <input type="checkbox"/> Other/Relationship _____	
Home Address				
Employer Name				
Email				
Telephone Number in the order in which you prefer to be called	Classification?	Accept Text?	Unlisted?	Call for Attendance?
1 st	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 nd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 rd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Solvay Union Free School District has my permission to share educational records with this person.				<input type="checkbox"/> Yes <input type="checkbox"/> No

ADDITIONAL PARENT/GUARDIAN INFORMATION				
Living in household with student <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name		<input type="checkbox"/> Relationship _____		
Home Address				
Employer Name				
Email				
Telephone Number in the order in which you prefer to be called	Classification?	Accept Text?	Unlisted?	Call for Attendance?
1 st	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 nd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3 rd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Solvay Union Free School District has my permission to share educational records with this person.				<input type="checkbox"/> Yes <input type="checkbox"/> No

SIBLINGS AND ALL PERSONS RESIDING WITH STUDENT AT SAME ADDRESS

Name	Birth Date	Grade	Gender M/F	Relationship to Student

Note: District policy and legal requirements provide that both parents have equal access to their child(ren) and school records unless court papers are on file with the district. Court papers are not required as a condition of your child's enrollment with the District.

SOLVAY UNION FREE SCHOOL DISTRICT STUDENT REGISTRATION (Page 3)

Student Name: _____

Has Student attended Solvay Schools before? ☐ Yes ☐ No If yes, please provide dates: _____

Is the student receiving Special Education (IEP/504) services: ☐ Yes ☐ No

If yes, please check any services listed below that your child has received in the past school year.

☐ Resource Room ☐ School Counseling ☐ Occupational Therapy ☐ Physical Therapy
☐ Special Class Placement ☐ Outside Counseling ☐ Speech Therapy ☐ Other

Is the student receiving any Academic Intervention Services (AIS) for any of the following areas (check all that apply):

☐ English ☐ Math ☐ Science ☐ Social Studies

Did the student receive ESL (English as a Second Language) services from a prior school? ☐ Yes ☐ No

Do you have any other concerns about your child? ☐ Yes ☐ No If yes, please explain: _____

Has your student ever repeated a grade in school? ☐ Yes ☐ No If yes, what grade level(s)? _____

If this student is transferring from another school, please give the name and address of the former school.

LAST SCHOOL ATTENDED: _____ GRADE: _____

ADDRESS OF SCHOOL: _____ FAX # _____

PHONE #: _____

Parent/Guardian Statement

Permission is hereby granted to the Solvay Union Free School District to obtain Health/Medical, Academic, CSE/IEP, Attendance, Discipline and Psychological/Social/Emotional records from the above listed school as well as transfer records to a new school in the event of a move to another district or state.

I certify that the information provided is accurate to the best of my knowledge and that I have legal custody of the above named child.

I understand that:

1. If I provide false information on this registration form to the Solvay Union Free School District, I may be committing the crime of perjury in the third degree (a class A misdemeanor);
2. If I provide false information on this registration form to the Solvay Union Free School District with the intent to defraud the Solvay Union Free School District, I may be committing the crime of perjury in the second degree (a class E felony); and
3. I may be prosecuted on criminal charges for such false information.

Signature of parent / guardian: _____

Date: _____

Solvay Union Free School District's Residency Determination

Student Name: _____

Please answer the following questions. This will help determine whether you are residents of the Solvay Union Free School District.

1. Is the current address and living arrangement in the Solvay Union Free School District the student's actual and only address/residence? ☐ Yes ☐ No
2. Is the place you claim as the base of operation where the child sleeps and resides? ☐ Yes ☐ No
3. Does the student intend to remain permanently in the district? ☐ Yes ☐ No
4. Does the student live with the adult having permanent physical custody (custodian parent or guardian) of the student? ☐ Yes ☐ No

I understand that:

- *If I provide false information on this registration form to the Solvay Union Free School District, I may be committing the crime of perjury in the third degree (a class A misdemeanor);*
- *If I provide false information on this registration form to the Solvay Union Free School District with the intent to defraud the Solvay Union Free School District, I may be committing the crime of perjury in the second degree (a class E felony); and*
- *I may be prosecuted on criminal charges for such false information.*

Signature of parent/guardian: _____ Date: _____

These questions are asked in accordance with the McKinney-Vento Act 42 U.S.C. 1134a [2] and Education Law 3209 (1)(a). The answers to the following residency questions will provide information to help the Solvay Union Free School District determine the services a student may be eligible to receive.

To be completed by a Solvay Union Free School District official.

Is the student in temporary living arrangements due to the loss of housing or economic hardship?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the answer is YES, please complete the remainder of this form. If the answer is NO, you may stop here. The student is currently living...	
In a household with the custodial parent and/or legal guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No
In a shelter	<input type="checkbox"/> Yes <input type="checkbox"/> No
With more than one family or relatives in a house or apartment	<input type="checkbox"/> Yes <input type="checkbox"/> No
In a place not designed for ordinary sleeping accommodations such as a car, park, or transportation center/station (i.e. train, bus etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
In a motel, hotel, trailer park, camping ground or other similar situation due to the lack of alternative, adequate housing	<input type="checkbox"/> Yes <input type="checkbox"/> No
In an abandoned apartment/building	<input type="checkbox"/> Yes <input type="checkbox"/> No
In an Office of Children and Family Services (OCFS) facility awaiting permanent foster care placement	<input type="checkbox"/> Yes <input type="checkbox"/> No
As a migratory child by moving from place to place	<input type="checkbox"/> Yes <input type="checkbox"/> No
As an unaccompanied youth for whom no parent or person in parental relation is available	<input type="checkbox"/> Yes <input type="checkbox"/> No

Temporary Address:

Solvay Union Free School District's Federal Education Data Collection Form

Student Name: _____

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ Yes, Hispanic
☐ No, not Hispanic

2. Select one or more races from the following five racial groups [For question 2, check (✓) all groups that apply to your child; check (✓) at least ONE box.]:

☐ **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Native Hawaiian/Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Black or African American:** A person having origins in any of the Black racial groups of Africa.

☐ **White:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

3. What language is spoken at home: _____

4. What language does the student primarily speak? _____

5. Did the student receive English as a Second Language services from a prior school? ☐ Yes ☐ No



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

Lisette 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?	<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"/> Mother	<input type="checkbox"/> Father	_____ specify
	<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	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not write

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: ☐ 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:



IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____) - ____ - ____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

**To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program-
Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.**

2025-26 School Year

New York State Immunization Requirements

for School Entrance/Attendance¹

NOTES:
All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the “[ACIP-Recommended Child and Adolescent Immunization Schedule](#).” Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements **MUST** be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³	Not applicable		1 dose given after age 10 years	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

d. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age](#).

e. For further information, refer to the [CDC Catch-Up Guidance for Children 7 through 9 Years of Age](#).

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 12: 7 years).

a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.

b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 12.

c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

d. For further information, refer to the [CDC Catch-Up Guidance for Children 10 through 18 Years of Age](#).

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

e. For further information, refer to the [CDC Catch-Up Guidance for Children 4 Months through 17 Years of Age](#).

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.

c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.

d. Rubella: At least one dose is required for all grades (pre-kindergarten through 12).

6. Hepatitis B vaccine

a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 12: 10 years).

a. One dose of meningococcal conjugate vaccine is required for students entering grades 7, 8, 9, 10 and 11.

b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

d. If dose 1 was received at 15 months or older, only 1 dose is required.

e. Hib vaccine is not required for children 5 years or older.

f. For further information, refer to the [CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age](#).

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

d. If one dose of vaccine was received at 24 months or older, no further doses are required.

e. PCV is not required for children 5 years or older.

f. For further information, refer to the [CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age](#). *Depending on vaccine brand, schedule may change.

For further information, contact:

**New York State Department of Health
Division of Vaccine Excellence
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437**

**New York City Department of Health and Mental Hygiene
School Compliance Unit, Bureau of Immunization
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433**

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

2370

5/25

SOLVAY UNION FREE SCHOOL DISTRICT
P.O. Box 980 – 299 Bury Drive – Syracuse, NY 13209
STUDENT RECORDS REQUISITION

Previous School: _____ Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The following student has registered in our school district. Please exit student prior to the **projected enrollment start date*** listed below in order to avoid simultaneous/overlapping enrollment of this student at two districts with NYS.

Student Name: _____ Grade: _____ Date of Birth: _____

Registration Date: _____ Projected Enrollment Start Date*: _____

Did the student receive Special Education Services (please return with requested documents)? Yes No

For this student please send (by facsimile, email or postal service) all academic and health records as listed:

- | | | |
|----------------------------------|---------------------------------|---|
| - Current Report Card | - Standardized Test Results | - Health Appraisal & Immunization Records |
| - Grades at time of withdrawal | - Achievement Test Results | - Discipline/Conduct Reports |
| - Transcript of Grades | - State Assessments | - Regents Competency Test Results |
| - Academic Interventions Service | - Individualized Education Plan | |

Send all records to the school location checked off below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Solvay High School
600 Gertrude Avenue
Solvay, NY 13209
Phone: (315) 468-2551
Fax: (315) 484 -1404
Email: eburns@solvayschools.org | <input type="checkbox"/> Solvay Middle School
299 Bury Drive
Syracuse, NY 13209
Phone: (315) 487-7061
Fax: (315) 484 -1444
Email: gdiiflorio@solvayschools.org | <input type="checkbox"/> Solvay Elementary School
701 Woods Road
Solvay, NY 13209
Phone: (315) 488-5422
Fax: (315) 484 -1417
Email: sbligh@solvayschools.org |
|---|--|--|

In accordance with the final Regulation-Family Education Rights and Privacy Act (Buckley Act) dated June 17, 1977, it is no longer necessary to obtain written consent to release academic and health records between schools. It states that school officials, including teachers within the educational institution and officials of other schools in school systems in which they intend to enroll, may receive a student's records without written consents for such release. Thank you in advance for your assistance in this matter. If you have any questions, please be sure to call our offices at the numbers given above.

Parent Signature: _____ Date: _____

Solvay Union Free School District – Emergency Information

Please circle any information that is new or recently changed

Dear Parent/Guardian: We need the following information in order to reach you if your child becomes ill or injured during school hours. Please provide the following information for our records by **returning it to the Health Office as soon as possible**.

Student's Name: _____ Date of Birth: _____
Home Address: _____ Grade: _____

FATHER			
Contact first in the event of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Living in household with student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name: _____			
Address: _____			
Employer: _____			
Email: _____			
Phone numbers in the order in which you prefer to be called		Classification	
1 st	_____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
2 nd	_____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
3 rd	_____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager

MOTHER			
Contact first in the event of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Living in household with student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name: _____			
Address: _____			
Employer: _____			
Email: _____			
Phone numbers in the order in which you prefer to be called		Classification	
1 st	_____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
2 nd	_____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
3 rd	_____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager

Sitter: _____ Address: _____ Phone: _____
Physician: _____ Address: _____ Phone: _____
Dentist: _____ Address: _____ Phone: _____
Hospital Preference: _____

In the past year, has student:

1. Received any **immunization** not previously reported to the school? ☐ Yes ☐ No
2. Had any **illness, injury or operation**? ☐ Yes ☐ No If so, please write date and nature of illness, injury or operation: _____
Please send written information from the doctor regarding illness/injury/surgery.
3. Been examined by an **eye doctor**? ☐ Yes ☐ No Were **glasses** prescribed? ☐ Yes ☐ No
4. Currently taking **medication** at home? ☐ Yes ☐ No If yes, name and frequency: _____
5. Does medication need to be dispensed **in school**? ☐ Yes ☐ No If yes, please provide **written note from doctor and your written permission**. Medicine should be brought to school in the original bottle by parent. It will be kept locked in the Health Office and administered by the nurse per doctor's written order. This applies to both prescription and "over-the-counter" medications per New York State law.

Is there anything else concerning the health of your child which the school should know in order to give your child special care?
(Note: this information will be shared in confidence with appropriate teachers and staff on a need-to-know basis) _____

Please give the names of two persons to be called (other than those listed above) to transport your child home or to medical care if you cannot be reached. **These persons should be available during school hours and have an automobile.**

EMERGENCY CONTACT 1		EMERGENCY CONTACT 2	
Relationship to student: _____		Relationship to student: _____	
Name: _____		Name: _____	
Address: _____		Address: _____	
Phone numbers in the order in which you prefer to be called	Classification	Phone numbers in the order in which you prefer to be called	Classification
1 st	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	1 st	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager
2 nd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	2 nd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager
3 rd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager	3 rd	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Pager

In an emergency, if no person on this form is available, we will call an ambulance.

Parent or Guardian Signature: _____ Date: _____

Appendix A

Digital Equity Standard Survey Questions and Responses

*Collecting accurate data regarding digital resource access for our New York students will greatly help educators to better serve their students and families. In order to accomplish this, the New York State Education Department is asking parents or guardians to complete a Digital Equity survey (for each student in the family) in grades Kindergarten – Grade 12. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, **please answer each question below** and follow any additional instructions provided for submitting or returning the survey.*

Thank you for your time and cooperation.

Question 1: Did the school district issue your child a dedicated school or district-owned device for their use during the school year?

Responses: YES NO

Question 2: What is the device your child uses **most often** to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)

Responses: DESKTOP LAPTOP TABLET CHROMEBOOK SMARTPHONE NO DEVICE

Question 3: Who is the provider of the primary learning device identified in question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)

Responses: SCHOOL PERSONAL NO DEVICE

Question 4: Is the primary learning device (identified in question 2) shared with anyone else in the household?

Responses: SHARED NOT SHARED NO DEVICE

Question 5: Is the primary learning device (identified in question 2) sufficient for your child to fully participate in all learning activities away from school?

Responses: YES NO

Question 6: Is your child able to access the internet in their primary place of residence?

Responses: YES NO

Question 7: What is the primary type of internet service used in your child's primary place of residence?

Responses: RESIDENTIAL BROADBAND CELLULAR MOBILE HOTSPOT
COMMUNITY WIFI SATELLITE DIAL UP DSL OTHER
NONE

Question 8: In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?

Responses: YES NO

Question 9: What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

Responses: AVAILABILITY COST NONE OTHER

Student ID#: _____

**Solvay Union Free School District
Transportation Department
399 Beach Road
Syracuse, NY 13209**

IEP: Y____N____

Special Transportation: Y____N____

Phone: 315- 487-5842

Fax: 315-487-5857

Transportation Request Form

To start, update, or change student's transportation needs

Today's date: _____

Student Name: _____ ☐ Male ☐ Female
Last First Middle Initial

Home Address: _____
No. Street Area (i.e. Solvay Lakeland, Lindbergh Lawns)

Age: _____ Grade: _____ School: _____

Parent/Guardian Home Phone Number: _____ Day Care Number: _____

Cell Phone Number: _____ Work Phone Number: _____

When would you like the change to take place? _____ (NOTE: 48 HRS. MINIMUM TO PROCESS)

.....
Check one
☐ New to Our District: ☐ Childcare/After school: ☐ Change in Address:

AM Change:

Current Address: _____ New Address: _____

PM Change:

Current Address: _____ New Address: _____

Parent(s) Signature: _____ Print: _____

NOTE: A NEW TRANSPORTATION REQUEST FORM NEEDS TO BE FILLED OUT EVERY YEAR AND MAILED TO THE TRANSPORTATION DEPARTMENT

NOTE: In case of an "Early Dismissal," we will need to know the address where you would like your child to be transported.
.....

FOR TRANSPORTATION USE ONLY

Called: _____ Faxed: _____ Copy: _____

☐ Approved ☐ Denied Reason _____

Transportation Department Designee: Signature: _____

Bus # _____ Pick-up Time: _____ Pick-up Location: _____