



2018-2019 PROGRAM ENROLLMENT FORM

****Acceptance upon Final Review of Records by BOCES****

**SEND ALL PAPERWORK TO BOCES STUDENT DATA CENTER:
SDC@BTBOCES.ORG — FAX: 607-763-3614 — INTEROFFICE: ED CENTER #20**

STUDENT DEMOGRAPHICS

First Name:		MI:	Last Name:		
Birth Date:		Gender:	Grade: (As of 9/2018)	Hispanic:	Ethnicity:
		_____		<input type="checkbox"/> Yes or <input type="checkbox"/> No	_____
School District:		Dist School Bldg:	District of Residence:	Local Student ID #:	9 th Grade Entry (Sept):
Disability:	If the student is classified, please <u>attach the IEP</u> . If the student has a <u>BIP</u> , please include it.				ELL Years:

Meal Status:			Assessment Type:		
<input type="checkbox"/> Free	<input type="checkbox"/> Not Free	<input type="checkbox"/> Reduced	<input type="checkbox"/> NYS Assessments	<input type="checkbox"/> NYS Alternate Assessments	

Student's Mailing Address:					
Parent/Guardian Information 1:		Relationship:		Lives with this Guardian: <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Name:					
Address:					
Home Phone:		Work Phone:		Cell Phone:	
Parent/Guardian Information 2:		Relationship:		Lives with this Guardian: <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Name:					
Address:					
Home Phone:		Work Phone:		Cell Phone:	

ADD/CONTINUE STUDENT: If this placement is an Additional Request for Services, please process an ARFS form PRIOR to enrollment.

BOCES Site:		BOCES Program:		Session:	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> All Day	
CTE Course:				Session:	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> All Day	
Tentative Start Date:		Note: Program/Course enrollment is on a "First Come-First Served" basis.			

CHANGE STUDENT PLACEMENT:

FROM BOCES Site:		FROM BOCES Program or Course:		Session:	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> All Day	
TO BOCES Site:		FROM BOCES Program or Course:		Session:	
				<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> All Day	
Desired Effective Date:					

DROP STUDENT: If student is enrolled in multiple BOCES programs, please specify ALL program(s)/service(s) you would like discontinued.
PLEASE NOTE: Drops are processed on the date received in the BOCES Student Data Center and CANNOT be back dated.

FROM BOCES Site:		FROM BOCES Program or Course:			
Desired Effective Date:		Drop Reason:			

Signature (ADMIN/CSE/CNSLR):			Date:		



RELATED SERVICES ENROLLMENT

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PROVIDE RELATED SERVICES:

This Student is in a BOCES program:

Yes or No

For Related Services ONLY:

Yes or No

Effective Date:

Location of Service:

	Services	FREQ	MIN	CYCLE	G/I	AND/OR	FREQ	MIN	CYCLE	G/I
<input type="checkbox"/>	SKILLED NURSE			—	—				—	—
<input type="checkbox"/>	STUDENT PHYSICAL <i>(Grades K,1,3,7,& 10 – Special Ed also grade 5)</i>									

Check all that apply and select % - ONLY possible choices are 50%, 100%

Aide %
 Monitor %
 Interpreter %
 Scribe (*% TBD by BOCES*) %

**Below are the ONLY Related Services offered by BOCES – they are NOT INCLUDED in program & generate additional costs.
 For clarification, contact Sue Tiffany at 763-3318.**

<input type="checkbox"/>	Counseling <i>(In addition to Program)</i>			—	—				—	—
<input type="checkbox"/>	Indirect Consultant Teacher			—	—				—	—
<input type="checkbox"/>	Direct Consultant Teacher			—	—				—	—
<input type="checkbox"/>	Subject Area:			—	—				—	—
<input type="checkbox"/>	Subject Area:			—	—				—	—
<input type="checkbox"/>	Subject Area:			—	—				—	—
<input type="checkbox"/>	Subject Area:			—	—				—	—
<input type="checkbox"/>	Family Training/Counseling			—	—				—	—
<input type="checkbox"/>	Occupational Therapy - Please Include Prescription			—	—				—	—
<input type="checkbox"/>	Physical Therapy - Please Include Prescription			—	—				—	—
<input type="checkbox"/>	Adaptive PE <i>(In Addition to Program)</i>			—	—				—	—
<input type="checkbox"/>	Speech (Disabled)			—	—				—	—
<input type="checkbox"/>	Hearing Impaired			—	—				—	—
<input type="checkbox"/>	Visually Impaired			—	—				—	—
<input type="checkbox"/>				—	—				—	—

Amended IEP Attached *(Indicate changes made):*

Individual Evaluation:
 Please Describe:
Purpose:

Signature *(ADMIN/CSE/CNSLR):*

Date: