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:	Home Language:
	____		☐ Yes or ☐ No	____	

School District:	Dist School Bldg:	District of Residence:	Local Student ID #:	9th Grade Entry (Sept):

Disability:	If the student is classified, please attach the IEP. If the student has a BIP, please include it.	ELL Years:

Meal Status:	Assessment Type:
☐ Free ☐ Not Free ☐ Reduced	☐ NYS Assessments ☐ NYS Alternate Assessments

Student's Mailing Address:					
Parent/Guardian Information 1:		Relationship:		Lives with this Guardian: ☐ **Yes** or ☐ **No**	
Name:					
Address:					
Home Phone:		Work Phone:		Cell Phone:	
Parent/Guardian Information 2:		Relationship:		Lives with this Guardian: ☐ **Yes** or ☐ **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:
		☐ AM ☐ PM ☐ All Day
CTE Course:		**Session:**
		☐ AM ☐ PM ☐ 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:
		☐ AM ☐ PM ☐ All Day
TO BOCES Site:	**FROM BOCES Program or Course:**	**Session:**
		☐ AM ☐ PM ☐ 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:**	

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Enriching Lives Through Education

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
☐	SKILLED NURSE			____	__				____	__
☐	STUDENT PHYSICAL *(Grades K,1,3,7,& 10 – Special Ed also grade 5)*									

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.

☐	Counseling *(In addition to Program)*			____	__				____	__
☐	Indirect Consultant Teacher			____	__				____	__
☐	Direct Consultant Teacher			____	__				____	__
☐	Subject Area:			____	__				____	__
☐	Subject Area:			____	__				____	__
☐	Subject Area:			____	__				____	__
☐	Subject Area:			____	__				____	__
☐	Family Training/Counseling			____	__				____	__
☐	Occupational Therapy - Please Include Prescription			____	__				____	__
☐	Physical Therapy - Please Include Prescription			____	__				____	__
☐	Adaptive PE *(In Addition to Program)*			____	__				____	__
☐	Speech (Disabled)			____	__				____	__
☐	Hearing Impaired			____	__				____	__
☐	Visually Impaired			____	__				____	__
☐				____	__				____	__

☐	Amended IEP Attached *(Indicate changes made)*:		
☐	Individual Evaluation:	*Please Describe:*	
		Purpose:	

Signature *(ADMIN/CSE/CNSLR)*:		**Date:**	