SOUTHERN WESTCHESTER BOCES
BOARD OF COOPERATIVE EDUCATIONAL SERVICES

# TASC ENROLLMENT PACKET 2019-2020

Today's Date: _____ Is this a returning Student? [ ] YES [ ] NO
Sending District: _____ Home District: _____
Billing District: _____ School Name: _____

## STUDENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Male / Female / X: _____

Home School Student ID#: _____ Year Student Entered 9th Grade: _____

Student Grade Level in September: _____ Anticipated Graduation Year: _____

Home School Counselor: _____ Is the student pursuing a CDOS Credential? [ ] Yes [ ] No

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

**Is the student:** [ ] A single parent [ ] A displaced homemaker [ ] Eligible for free lunch
***(student only)*** [ ] Economically disadvantaged [ ] An English Language Learner [ ] Eligible for reduced lunch

**Are there any other barriers to achievement?** [ ] YES [ ] NO

If so, please explain: _____

**Is the Student of Hispanic, Latino, or Spanish Origin?** [ ] YES [ ] NO
**Is the Student Multiracial?** [ ] YES* [ ] NO **If YES, please check all that apply below*

**Ethnicity of Student:** [ ] American Indian/Alaskan Native [ ] White
[ ] Asian [ ] Black or African American [ ] Pacific Islander or Hawaiian

**Dominant Language:** _____

**Is the transcript attached?** [ ] YES* [ ] NO **If not, please attach current transcript*

**Does the student have an IEP/504?** [ ] YES* [ ] NO **If so, please attach most current IEP / 504*

****Finalized IEP /504 for 2019-20 must be received by Sept 1ST*** ****Please share with IEP Direct***

## PARENT/GUARDIAN INFORMATION

**Mother/Guardian:** _____ **Father/Guardian:** _____
Home Telephone #: _____ Home Telephone#: _____
Home Address: _____ Home Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Work #: _____ Cell #: _____ Work #: _____ Cell #: _____
Email: _____ Email: _____

## EMERGENCY CONTACT

**Name:** _____ **Name:** _____
Home Telephone #: _____ Home Telephone #: _____
Work #: _____ Cell #: _____ Work #: _____ Cell #: _____
Email: _____ Email: _____
Relationship: _____ Relationship: _____

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## HEALTH HISTORY

**Student Name:** _____

**Doctor's Name:** _____

Doctor's Telephone #: _____

Is student taking medication? _____ If so, why? _____

Name of Medication(s)?: _____

_____

Dosage?: _____

Frequency?: _____

Student has the following condition(s) which require special consideration in an emergency:

_____

_____

Any Physical Reaction(s)?: _____

_____

Has student had any of the following?

| | | | |
|---|---|---|---|
| Epilepsy | [ ] Yes | [ ] No | If so: Grand Mal_____ Petit Mal_____ |
| Asthma | [ ] Yes | [ ] No | |
| Allergies | [ ] Yes | [ ] No | If so, describe_____ |
| Bee Sting | [ ] Yes | [ ] No | If so, indicate treatment: [ ] Oral Med. [ ] Injection [ ] Hospital |
| Diabetes | [ ] Yes | [ ] No | |
| Heart Disease | [ ] Yes | [ ] No | |
| Loss of Consciousness | [ ] Yes | [ ] No | |
| Head Injury | [ ] Yes | [ ] No | |
| Kidney Disease | [ ] Yes | [ ] No | |
| Blood Pressure Problem | [ ] Yes | [ ] No | |
| Vision Impairment | [ ] Yes | [ ] No | |
| Hearing Impairment | [ ] Yes | [ ] No | |

Date of last Tetanus Injection? _____

I have read the above information and answered the questions to the best of my knowledge.

I am the parent/guardian of the child named on this application. In the event he/she needs emergency treatment and I cannot be reached, I request the emergency treatment be administered at the nearest hospital.

_____ _____

PARENT / GUARDIAN SIGNATURE DATE