WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Registration Packet

Welcome to the Whitehall Central School District!

Please complete this packet and have all required documentation prior to scheduling an appointment with the district registrar.

Registration for all children entering the Whitehall Central School District are **by appointment only** at the Whitehall Jr.-Sr. High School Guidance Office. Please call 518-499-0480 to schedule an appointment.

A parent/legal guardian must be present at the time of registration.

PARENTS MUST PROVIDE THE FOLLOWING, ALONG WITH THIS PACKET, TO COMPLETE THE REGISTRATION PROCESS:

- ☐ **Parent/Legal Guardian Photo ID**
- ☐ **Proof of Age** (any of the following: Birth Certificate, Passport, or Baptismal Certificate)
- ☐ **Two Proofs of Residency:** A list of acceptable documents can be found on the Proof of Residency Form.
- ☐ **Proof of Immunizations and a Physical:** must be signed or stamped by a State Licensed health care provider. Proof may be faxed to 518-499-1760 directly from the physician's office.
- ☐ **Custody Papers** (if applicable)
- ☐ **Individualized Education Plan (if applicable) and Academic Records**.
  All academic records must be received from the previous school before a school schedule can be created. We will request these records from the previous district if you cannot provide copies.

If any of the above documents are unavailable, the school district may consider other forms upon approval.

Once you have registered and all documents have been received, you will be contacted by the appropriate school:

Whitehall Elementary School **99 Buckley Road** **518-499-0330**	**Whitehall Jr.-Sr. High School** **87 Buckley Road** **518-499-1770**
Arrival: 8:35 am **Dismissal: 3:10 pm**	**Arrival: 7:30 am** **Dismissal: 2:10 pm**

WHITEHALL CENTRAL SCHOOL DISTRICT

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518-499-0480

Student Registration Form

Student Name: _____ **Registration Date:** _____

Parent/Guardian Information

Primary
Parent/Guardian Name: _____ Relationship to Child: _____ **Active Military:** □ Yes □ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____ E-Mail Address: _____

Parent/Guardian Name: _____ Relationship to Child: _____ **Active Military:** □ Yes □ No

Home Phone: _____ Cell Phone: _____ Work Phone: _____ E-Mail Address: _____

Home Address (if different than student's): _____ Receives Mail: □ Yes □ No

Student Resides with: __ Parents __ Mother __ Father __ Foster Parents (Please provide DSS-2999) __Other: _____

Legal Arrangements? □ No □ Yes (please provide court docs) □ Joint Custody □ Sole Custody □ Temporary Custody □ Visitation

Student Information

Student's Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Grade Level: _____

Gender: □ Male □ Female Home Phone: _____

Residential Address: _____
Street *Apt #/Unit/Floor*

_____
City *State* *Zip*

Mailing Address
(If different than above): _____

Has your child previously attended Whitehall CSD?
□ Yes □ No

Does your child have an IEP (Individualized Education Plan)?
□ Yes □ No

Ethnicity - check those that apply:
□ Hispanic □ Not Hispanic

Race – check those that apply:
□ American Indian or Alaska Native □ Asian
□ Black or African-American □ White
□ Native Hawaiian or other Pacific Islander

Household Information

List all children residing in residence	Gender	Birthdate	Grade	School

---------- Proceed to the Next Page ----------

For Official Use Only:

Documents provided to the District:

□ Photo ID
□ Birth Certificate
□ Immunization Record
□ Physical
□ Dental Certificate

Proof of Residency:
□ Deed/Tax Bill
□ Utility Bill
□ Driver's License
□ Notarized Letter & Home Visit
□ Other _____
□ Signed Lease □ STAC □ Free/Reduced Lunch

Custody Papers:
□ DSS 2999
□ Custody

Student ID #: _____
Grade: _____
Referrals: □ CSE □ ELL
Stamp Date: _____
Registrar Signature: _____

WHITEHALL CENTRAL SCHOOL DISTRICT

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518-499-0480

Student Registration Form

Emergency Contact

Name: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relationship to Student: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Educational History

Please check any services that your child had at his/her previous school:

Individualized Education Plan (IEP)	□ No	□ Yes	□ Declassified	□ I don't know
Occupational Therapy (OT)	□ No	□ Yes	□ Declassified	□ I don't know
Physical Therapy (PT)	□ No	□ Yes	□ Declassified	□ I don't know
Speech or Language	□ No	□ Yes	□ Declassified	□ I don't know
504 Accommodation Plan	□ No	□ Yes	□ Declassified	□ I don't know
Academic Intervention Services in Math and/or Reading	□ No	□ Yes	□ Declassified	□ I don't know
Alternative Learning Program	□ No	□ Yes	□ Declassified	□ I don't know

Please provide the last date your child attended school: _____

Other School Districts Attended ***(list most recent first):***

Please list all previous schools attended, including preschool. If more space is needed, attached additional pages.

School Name	Year(s) of Attendance	Grade	City, State

Photo Release

I hereby grant the Whitehall Central School District the absolute right and permission to use, reuse, copyright, and/or publish original student work, photographic pictures or video footage which includes/references me and/or my children, in conjunction with an actual or fictitious name. I understand this will be used for the purpose of illustration, promotion, and public relations of school programs and may appear in printed materials, video presentations, news coverage (both print and television) and/or on the district's website.

□ Yes □ No

PARENT CERTIFICATION AND SIGNATURE

By signing this form, I acknowledge the responsibility of providing the district with accurate information.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Student Registration Form

New York State Education Law requires all NEW ENTRANTS and students in Pre-K or K, 2nd, 4th, 7th and 10th grades to have a physical exam. The District strongly recommends that your own physician conducts your child's health physical because he/she is most familiar with your child's development. We ask that your physician use the Health Appraisal form provided by the school or their own form and have it at the time of registration or return it to the school nurse of the building your child will attend. **If a physical form from your doctor/pediatrician is not returned within 30 days, your child will have to be examined by the school physician.**

A law was recently enacted that expands health screenings to include dental health of students in New York. The school can provide a certificate for you to take to your child's dentist and once it is completed, it should be returned to the School Nurse.

Thank you for your cooperation with this new requirement. Our students benefit when we work together to promote the health and achievement of all students.

Medical/Health Information

Health History – If your child has had any of the following health problems or disease, please check below.

□ ADD/ADHD □ Allergies: □ Animals □ Bees □ Food(s): _____ _____ □ Medication(s): _____ _____ □ Seasonal □ Other □ Anemia □ Anxiety □ Asthma	□ Bone/Joint/Muscle Problems □ Blood Disorders □ Cerebral Palsy □ Chicken Pox □ Chronic Ear Infections □ Concussion (date): _____ □ Cystic Fibrosis □ Depression □ Diabetes □ Hearing Loss □ Heart Disease or murmur □ Hepatitis	□ Learning Disability □ Leukemia □ Lyme Disease (date): _____ □ Migraines □ Speech Problems □ Strep □ Surgery/Hospitalizations: _____ _____ _____ □ Scarlet Fever □ Seizure Disorder □ Serious Injuries □ Tuberculosis	□ Vision Problems Last Vision Exam: _____ Glasses: □ Yes □ No Other Health Issues: _____ _____ _____ _____ _____ Comments: _____ _____ _____

Please be aware that ANY medication(s) taken in school, requires a written order from a physician and written permission from a parent/guardian. This includes over the counter/non-prescription medication(s).

For the safety and wellbeing of your child, you must be accessible in the event of illness or injury. Notify the school immediately if any of the emergency numbers or contacts you provided change. Parents must pick up their child when he/she is ill or injured. If parents are unable to do so, they must designate a responsible adult to pick up and attend to their child.

Your signature below allows us to share pertinent medical information in written form (name, diagnosis, symptoms of condition, proper treatment and actions for staff to take, if necessary) with school staff. Also, please indicate whether your child will be wearing Medical-Alert Information.

If you have any questions or concerns, please call your child's school Health Office:

Whitehall Elementary: Donna Tipton – 518-499-0330 ext. 2076

Whitehall Jr.-Sr. High – Leslie Rathbun – 518-499-1770 ext. 2009

_____ _____

Parent/Guardian Signature *Date*

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Authorization for Release of Records/Information

Date of Request: _____

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

School Last Attended: _____

Address: _____

_____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____
Parent or Guardian

The above named student has enrolled in our school district. We would appreciate copies of the following records concerning this student:

- ✓ Academic Records (Transcript/report card)
- ✓ Standardized Test scores
- ✓ Discipline Records
- ✓ Attendance Records
- ✓ Health

***All confidential and IEP documentation should be sent to:**
CSE Office: Fax: 518- 499-1760 or Transfer via IEP Direct

- ✓ Individualized Educational Plan (IEP)
- ✓ Psychological

Please provide the following documents via fax to the **Registrar 518-499-1760**, if the box below is checked:

- □ Immunization, Health Records and Birth Certificate

Send Records to:

□ **Whitehall Elementary School**
99 Buckley Road
Whitehall, NY 12887
Phone: 518-499-0330
Fax: 518-499-1752

□ **Whitehall Jr.-Sr. High School**
87 Buckley Road
Whitehall, NY 12887
Phone: 518-499-0480
Fax: 518-499-1760

□ **CSE Office **Special Education****
87 Buckley Road
Whitehall, NY 12887
Phone: 518-499-1771
Fax: 518-499-1760

WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 Buckley Road
Whitehall, New York 12887-3633
518-499-0480

Residency Questionnaire

Student Name: _____ Gender: ☐ M ☐ F Date of Birth: _____

Physical Address: _____ City/State/Zip: _____

McKinney-Vento Assistance Act

The answers 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 do not have 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 an emergency or transitional shelter.
- ☐ With another family or other person due to a loss of housing or economic hardship.
- ☐ With an adult who is not a parent or guardian or alone without an adult.
- ☐ In a hotel/motel.
- ☐ In a car, park, bus, train, campsite, public place, abandoned building.
- ☐ Other temporary living situation (Please specify): _____
- ☐ **Student is in permanent housing.**

If a student is in **permanent housing** please sign below and **fill out the Residency Form on the next page**.

If **any of the other boxes were checked**, please sign below and you will need to **fill out a Designation Form (STAC 202)** which the school will provide you.

Print: _____ Signature: _____

Parent/Guardian or Student (unaccompanied youth) Parent/Guardian or Student (unaccompanied youth)

Date: _____

WHITEHALL CENTRAL SCHOOL DISTRICT

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518-499-0480

Residency Form

Parent/Guardian: _____ Student Name: _____ Gr: ____

Relationship to Student(s): _____ Student Name: _____ Gr: ____

Physical Address: _____ Student Name: _____ Gr: ____

City/State/Zip: _____ Student Name: _____ Gr: ____

Please check one: ☐ **Own** ☐ **Rent** ☐ **Reside w/ a district resident**

When you register OR move within the Whitehall Central School District, you are required to provide the school district with Proof of Residency. Post Office Boxes will not be accepted.

You must provide at least two (2) proofs from the following list:

(Your name and address must be indicated on these documents and be current)

If you OWN:	If you RENT:	Reside with a district student:
☐ Tax Bill ☐ House Deed ☐ Mortgage Statement w/in 30 days ☐ Current Homeowner's Insurance ☐ Current Driver's License ☐ Utility Bill w/in 30 days ☐ A record of voter registration	☐ Documents issued by the federal, state or local agencies. ☐ Utility Bill w/in 30 days ☐ Lease agreement (must be signed w/ landlord's name and phone number) ☐ Current Renter's Insurance	☐ Notarized letter from the district resident along w/ the resident's proof of ownership (house deed, tax bill or mortgage statement) A residency check will be done by a school representative as well. District Use Only: Date of Home Visit: _____ ☐ Verified ☐ Not verified

Once this form and documentation are received by the District, residency will be verified.

_____ _____
Parent/Guardian Signature Date

District Use:

_____ _____
Approved By Date

TRANSFER NOTIFICATION

This form must be completed for all transfer students and submitted to the Section 2 office.

UPON RECEIPT IN THE SECTION OFFICE, THE STUDENT IS ELIGIBLE TO PRACTICE; BUT CANNOT PARTICIPATE IN A CONTEST UNTIL APPROVED BY THE SECTION.

***Please Note*: Make sure all available information/documentation is submitted prior to the Transfer Committee's review. *NO appeal* will be entertained involving additional information that WAS AVAILABLE but not included at the time of the original submission.**

PLEASE CHECK ONLY ONE (1) of THE FOLLOWING.

Waiver Request:

_____ **Financial** – Requires documented proof of a significant loss of income or a significant increase in expenses. OR

_____ **Health & Safety** – Written documentation from the Superintendent of Schools or HS Principal of the previous school indicating the specific circumstances which necessitated the transfer.

_____ **School District of Residence (SDR):** (No change of residence, school registration change only.) Student is transferring to a school within the district boundaries of his/her residence.

Exemption:

_____ **Divorced/Legally Separated Parents:** A student from divorced or legally separated parents who moves into a new school district with one of the aforementioned parents is exempt provided it occurs once every six (6) months. The legal separation agreement or divorce document must address custody, child support, spousal support and distribution of assets and be filed with the County Clerk or issued by a Judge. **(proof required)**

_____ _____

Parent(s) Signature Attesting to Above **Athletic Director's Verification**

_____ **Homeless:** Student declared homeless by the Superintendent under McKinney-Vento Legislation (NYSED 100.2) **(STAC on file at the school)**

_____ **No Corresponding Change of Address:** This transfer has no corresponding change of address nor does a waiver or exemption apply.

We understand that the student is ineligible per the NYSPHSAA Transfer Rule and subject to the limitations contained in NYSPHSAA Handbook #31(b) passed July 2019.

_____ **Residency Change**: The entire family has abandoned the previous address and physically residing at the current address.

By signing this document, I/We attest to the truth and accuracy of any and all information provided on this form. In the case of a Change of Residency, I/We attest that our previous residence has been abandoned by the immediate/entire family and our current residence has been established through action and intent. I/We attest that the immediate/entire family will be physically residing at our current address as inhabitants and intend to remain indefinitely. (The mere renting of property within the District does not confer residency. The Superintendent determines residency for enrollment, but this more restrictive requirement is needed for athletic eligibility per NYSPHSAA Regulations.) I/We attest that the student has transferred without inducement, recruitment or having sought an athletic advantage.

Parent Signature: _____ Date: _____

Receiving School: _____ Student's Name: _____ Date of Birth: _____

Date of Registration/Transfer: _____ Grade Level: ____ Date Entered 9th Grade _____ Did Student Repeat Any Grades: YES NO

Student/Entire Family Previous Address: _____

Student/Entire Family Present Address: _____

Parent(s) Names and Current Addresses

Parent #1: Name _____ Address: _____

Parent #2: Name _____ Address: _____

Name of Previous School: _____ Did student participate in high school athletics at previous school? YES NO

OVER

TO BE COMPLETED BY RECEIVING SCHOOL'S ATHLETIC DIRECTOR IN CONVERSATION WITH PREVIOUS SCHOOL.

Dates of Attendance and Withdrawal of all Previous Schools: (grades 7-12)

1. School: _____ Attendance Dates: _____ Date of Withdrawal _____
2. School: _____ Attendance Dates: _____ Date of Withdrawal _____
3. School: _____ Attendance Dates: _____ Date of Withdrawal _____

List All High School Sports Student Has Played (7-12 grade)
Most Recent First

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sport(s): _____ Year: _____ Level: _____

Sports history verified by Receiving School's Athletic Director by:

_____ Telephone Conversation with _____ Date: _____

_____ E-mail/Fax with _____ Date: _____

Failure to confirm after three (3) documented attempts:

1. Date/Time: _____ Method: _____
2. Date/Time: _____ Method: _____
3. Date/Time: _____ Method: _____

The Receiving School's Athletic Director has reviewed and verified all information on this document as accurate and true to the best of his/her knowledge.

Athletic Director Reviewed & Verified: Signature: _____ Date: _____

The undersigned hereby certify that the student named herein has transferred to his/her present school without inducement, recruitment or having sought an athletic advantage.
The receiving school's administration is responsible for verification for these and other eligibility requirements.

Superintendent's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

Athletic Director's Signature: _____ Date: _____

** **If any information provided in this document by the parent(s) and/or Athletic Director is deemed to be inaccurate or false, will result in Eligibility Violations.**

Rev. Nov. 2019

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means, that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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

Lissette Colón-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?	❑ English	❑ Other *specify*	
2. What was the first language your child learned?	❑ English	❑ Other *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	❑ Guardian(s) *specify*
4. What language(s) does your child understand?	❑ English	❑ Other *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: