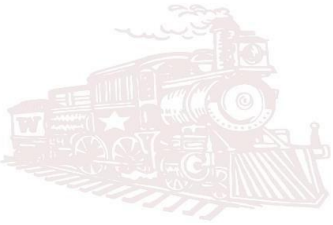


WHITEHALL CENTRAL SCHOOL DISTRICT



P.O. Box 29, 87 & 99
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**. Please call Mrs. **Trishia Jones** 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:

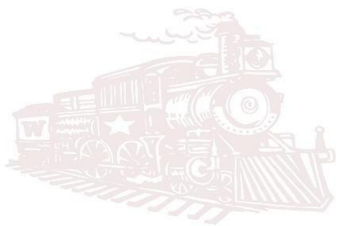
- Parent/Legal Guardian Photo ID**
- Proof of Age** (any of the following: Birth Certificate, Passport, or Baptismal Certificate)
- Two Proofs of Residency:** A list of acceptable documents can be found on the Proof of Residency Form.
- Proof of Immunizations and a Physical:** must be signed or stamped by a State Licensed health care provider. Proof may be faxed to 518-564-0053 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:

<p>Whitehall Elementary School 99 Buckley Road</p> <hr/> <p>518-499-0330</p>	<p>Whitehall Jr.-Sr. High School 87 Buckley Road</p> <hr/> <p>518-499-1770</p>
<p>Arrival: 8:15 am Dismissal: 3:10 pm</p>	<p>Arrival: 7:30 am Dismissal: 2:00 pm</p>



WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633

518-499-0480

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

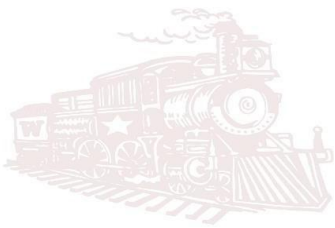
Student ID #: _____

Grade: _____

Referrals: CSE ELL

Stamp Date: _____

Registrar Signature: _____



WHITEHALL CENTRAL SCHOOL DISTRICT

**P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633**

518-499-0480

Emergency Contact			
Name: _____	Relationship to Student: _____		
Home Phone: _____	Cell Phone: _____	Work Phone: _____	
Name: _____	Relationship to Student: _____		
Home Phone: _____	Cell Phone: _____	Work Phone: _____	

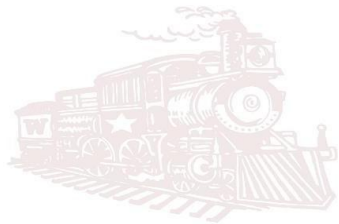
Educational History				
Please check any services that your child had at his/her previous school:				
Individualized Education Plan (IEP)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know
Occupational Therapy (OT)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know
Physical Therapy (PT)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know
Speech or Language	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know
504 Accommodation Plan	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know
Academic Intervention Services in Math and/or Reading	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know
Alternative Learning Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I don't know

Please provide the last date your child attended school: _____

Other School Districts Attended <i>(list most recent first):</i>			
<i>Please list all previous schools attended, including preschool. If more space is needed, attach additional pages.</i>			
School Name	Year(s) of Attendance	Grade	City, State

Photo Release
<p>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.</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

PARENT CERTIFICATION AND SIGNATURE			
<p>By signing this form, I acknowledge the responsibility of providing the district with accurate information.</p>			
<p>_____ Parent/Guardian Signature</p>	<p>_____ Date</p>	<p>_____ Parent/Guardian Signature</p>	<p>_____ Date</p>



WHITEHALL CENTRAL SCHOOL DISTRICT

**P.O. Box 29, 87 & 99 Buckley Road
Whitehall, New York 12887-3633**

518-499-0480

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.

<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Allergies: <input type="checkbox"/> Animals <input type="checkbox"/> Bees <input type="checkbox"/> Food(s): _____ <input type="checkbox"/> Medication(s): _____ <input type="checkbox"/> Seasonal <input type="checkbox"/> Other <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma	<input type="checkbox"/> Bone/Joint/Muscle Problems <input type="checkbox"/> Blood Disorders <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Concussion (date): _____ <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Disease or murmur <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Learning Disability <input type="checkbox"/> Leukemia <input type="checkbox"/> Lyme Disease (date): _____ <input type="checkbox"/> Migraines <input type="checkbox"/> Speech Problems <input type="checkbox"/> Strep <input type="checkbox"/> Surgery/Hospitalizations: _____ _____ _____ <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Serious Injuries <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Vision Problems Last Vision Exam: _____ Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

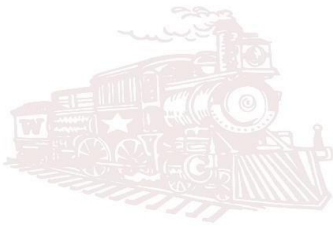
Your signature below allows us to share pertinent medical information in written form (name, diagnosis, symptoms of condition, proper treatment and actions for staff to take, if necessary) with school staff. Also, please indicate whether your child will be wearing Medical-Alert Information.

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

Whitehall Elementary: Nicole Molinero – 518-499-0330 ext. 2076
 Whitehall Jr.-Sr. High – Carly Pinkowski – 518-499-1770 ext. 2009

Parent/Guardian Signature

Date



WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99
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: _____

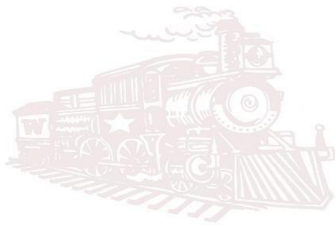
Fax: _____

Signature: _____

Date: _____

Parent or Guardian

<p>The above named student has enrolled in our school district. We would appreciate copies of the following records concerning this student:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Academic Records (Transcript/report card) <input checked="" type="checkbox"/> Standardized Test scores <input checked="" type="checkbox"/> Discipline Records <input checked="" type="checkbox"/> Attendance Records <input checked="" type="checkbox"/> Health 	<p>Send Records to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Whitehall Elementary School 99 Buckley Road Whitehall, NY 12887 Phone: 518-499-0330 Fax: 518-564-0053 <input type="checkbox"/> Whitehall Jr.-Sr. High School 87 Buckley Road Whitehall, NY 12887 Phone: 518-499-0480 Fax: 518-564-0053 <input type="checkbox"/> CSE Office **Special Education** 87 Buckley Road Whitehall, NY 12887 Phone: 518-499-1771 Fax: 518-564-0053
<p>*All confidential and IEP documentation should be sent to: CSE Office: Fax: 518- 564-0053 or Transfer via IEP Direct</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Individualized Educational Plan (IEP) <input checked="" type="checkbox"/> Psychological 	
<p>Please provide the following documents via fax to the Registrar 518-564-0053, if the box below is checked:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Immunization, Health Records and Birth Certificate 	



WHITEHALL CENTRAL SCHOOL DISTRICT

P.O. Box 29, 87 & 99
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.

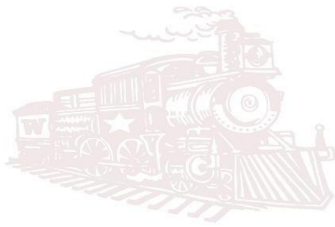
Print: _____ Signature: _____

Parent/Guardian or Student (unaccompanied youth)

Parent/Guardian or Student (unaccompanied youth)

Date: _____

WHITEHALL CENTRAL SCHOOL DISTRICT



P.O. Box 29, 87 & 99
Buckley Road Whitehall,
New York 12887-3633
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:
<ul style="list-style-type: none"><input type="checkbox"/> Tax Bill<input type="checkbox"/> House Deed<input type="checkbox"/> Mortgage Statement w/in 30 days<input type="checkbox"/> Current Homeowner's Insurance<input type="checkbox"/> Current Driver's License<input type="checkbox"/> Utility Bill w/in 30 days<input type="checkbox"/> A record of voter registration	<ul style="list-style-type: none"><input type="checkbox"/> Documents issued by the federal, state or local agencies.<input type="checkbox"/> Utility Bill w/in 30 days<input type="checkbox"/> Lease agreement (must be signed w/ landlord's name and phone number)<input type="checkbox"/> Current Renter's Insurance	<ul style="list-style-type: none"><input type="checkbox"/> Notarized letter from the district resident along w/ the resident's proof of ownership (house deed, tax bill or mortgage statement) <p>A residency check will be done by a school representative as well.</p> <hr/> <p style="text-align: center;">District Use Only:</p> <p>Date of Home Visit: _____</p> <p style="text-align: center;"><input type="checkbox"/> Verified <input type="checkbox"/> Not verified</p>

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

Parent/Guardian Signature

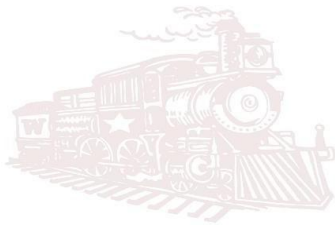
Date

District Use:

Approved By

Date

WHITEHALL CENTRAL SCHOOL DISTRICT



P.O. Box 29, 87 & 99
Buckley Road Whitehall,
New York 12887-3633
518-499-0480

STUDENT DIGITAL ACCESS SURVEY

Collecting accurate data regarding digital resource access for 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 - 12 grade. 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.

Student Name: _____ Grade: _____

Building: _____

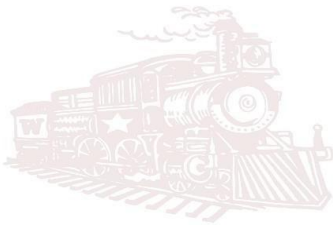
1. Is your child able to access the internet in their primary place of residence? ____ Yes or ____ No
2. What is the primary type of internet services used in your child's primary place of residence? (please check one)

<input type="checkbox"/> Residential Broadband	<input type="checkbox"/> Cellular	<input type="checkbox"/> Mobile Hotspot
<input type="checkbox"/> Community Wi-Fi	<input type="checkbox"/> Satellite	<input type="checkbox"/> Dial Up
<input type="checkbox"/> DSL	<input type="checkbox"/> Other	<input type="checkbox"/> None

3. In their primary residence, can you child complete the full range of learning activities, including video streaming and assignment uploading, without interruptions caused by slow or poor internet performance? __ Yes __ No
4. What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

Availability Cost Other None

WHITEHALL CENTRAL SCHOOL DISTRICT



P.O. Box 29, 87 & 99
Buckley Road Whitehall,
New York 12887-3633
518-499-0480

PURPOSE: As a parent/guardian you have the right to give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve the School Nurse to obtain records for your child(s) most recent health reports. At times Doctors offices do not send records over when they are asked, for us to be able to obtain them we need to have an authorization form on file. Please fill out the form below with the student(s) primary care physicians office information.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Student name: _____ Date: _____

Student DOB: _____ School District: _____

I hereby authorize the release of records:

From: _____ To: Whitehall Central School
(Name of agency/Person)

_____ 97 & 87 Buckley Road
(Street Address)

_____ Whitehall, NY 12887
(City, State, Zip Code)

Description of the records to be disclosed:

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/Guardian/Adult student signature Date

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: / /	Sex: € Male € Female	Will this be your child's first oral health assessment? € Yes € No		
Month Day Year				
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.



Lisette 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)

Please write clearly when completing this section.

*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.*

STUDENT NAME:		
<i>First</i>	<i>Middle</i>	<i>Last</i>
	<i>e</i>	
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>

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 _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father _____ <i>specify</i>
	<input type="checkbox"/> Guardian _____ an	_____ <i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>

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

H O M E LANGUAGE CODE _____

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? _____

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

Home Language Questionnaire (HLQ)—Page Two

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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>Mo DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER NYS STUDENT INFORMATION SYSTEM:
_____ <small>District Name (Number) & School</small>	_____ <small>Address</small>

Eligibility Screen for Migrant Education Services

Migrant Education Program services are free of charge and may include tutoring, assistance with health needs, educational field trips, summer programs, parent involvement activities, adult education, emergency

assistance and referrals to other services as needed. ***

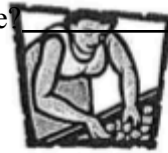
Has your family moved to a different school district in the last 3 years? YES _____ NO _____

In the last three years, has the parent or guardian of the child enrolling done farm work as a paid job? (Did they work on a dairy farm, planting, picking/harvesting fruits or vegetables, food processing or packaging, logging or tree farming?) YES _____ NO _____

If yes, what farm did you work on



Where



When?



If you can answer **YES** to **BOTH** of the above questions, your family **MAY** qualify for Migrant Education services. To be contacted by a Migrant Education recruiter, please complete the information below.

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Child's name _____ D.O.B. _____ Grade _____

Parents/Guardians

Mother's name _____ Father's Name _____

Home Address _____ Home

(Street Address)

Phone # _____

_____ Work or Message # _____

(City, Town or Village) (Zip)

School District _____ School Building _____

School Contact Person _____ Contact Number _____

To submit this referral please fax to the Herkimer BOCES at (315) 867-2087 or mail to the address above. **For** more information, please call the Migrant **Program** at (315) 867-2079.

Thank you for your assistance.