Student Name _____ , _____ **School / Grade** _____
Last First

Parent/Guardian Name _____ **Phone #** _____

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All Students, All of the Time

Dr. Paul J. Padalino
Superintendent of Schools

CHECKLIST FOR KINDERGARTEN REGISTRATION
The following documents are required for enrolling into the Kingston City School District

☐ **Birth Certificate, Passport, or Baptismal Certificate**

☐ **Immunization Record**
Prepared by a physician or authorized person who administers the immunizing agent and shall specify the vaccines given and the dates of administration, proof of past immunizations or proof of pending appointment with physician/medical practice.

☐ **Custody/Guardian papers**: Necessary if the child does not live with both biological parents

☐ **Parent or Guardian photo identification**: Driver's License, passport, state id.

☐ **District Residency**
One of the following residency proofs must be provided:

A. Owns home, or
1. Most recent utility bill/tax or mortgage statement – must have name and property/residence address

B. Rents home, or
1. Lease agreement, must have name property/residence address
2. Parent's name must appear on lease
3. Most recent utility bill – one only (electric, phone, water bill) must have
name and property/residence address

C. Affidavit of Property Owner/Landlord Form – Must be Notarized
1. To be completed by the landlord/property owner, in instances where there is no lease
2. If you are living with a relative, that person must complete the form and also provide you with a bill (electric, phone, water) showing their name and property/residence address

** The following will not be accepted as proof of residency: Driver's License, Checkbook, Rent Receipt, Car Insurance Cards, and Bank Statements.

****CLASSIFIED – YES or NO**

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:			GENDER:
Month	*Day*	*Year*	❑ 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:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

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:

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STUDENT HEALTH HISTORY

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition
(depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____
_____

Parent/Guardian Signature:_____Date:_____

This sample resource was created by the New York Statewide School Health Services Center and is located at
www.schoolhealthservicesny.com – SN Tool Kit – 8/14 _MH016/R0215

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Superintendent of Schools

AFFIDAVIT OF PROPERTY OWNER/LANDLORD
IN SUPPORT OF RESIDENCY IN THE KINGSTON CITY SCHOOL DISTRICT

I, _____ a property owner or manager/agent of the dwelling located at
(Name of Property Owner/Landlord or Property Manager)

_____ _____
(Street Address/Apt #) (City, State, Zip)

Hereby certify that I am renting space in this dwelling on a _____ basis beginning on _____
(Weekly/monthly/yearly) (Date)

The following persons are identified as tenants having the right to be occupants in the dwelling:

- Parent/Guardian:_____
- Parent/Guardian:_____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

Student Name: _____ Grade: _____

The payment of Electric Utility Bill is included in rent: Yes: _____ No: _____

I certify that the information provided on this form is true and correct and that the statements made herein are being made under the penalties of perjury, knowing that the Kingston City School District will rely upon them in determining whether the above-named child(ren) reside in the school district.

_____
(Signature of Property Owner/Landlord or Property Manager)

Sworn to before me on this
_____ Day of_____, 20_____

_____
(Print Name)

_____
(Notary Public)
State of:
County of:

60 Month Questionnaire *54 months 0 days through 72 months 0 days*

ASQ:SE-2

Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box ☑ that best describes your child's behavior. Also, check the circle ⊘ in the last column if the behavior is a concern.

Important Points to Remember:

- ❑ Answer questions based on what you know about your child's behavior.
- ❑ Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- ❑ Caregivers who know the child well and spend more than 15–20 hours per week with the child should complete ASQ:SE-2.

*If you have any questions or concerns about your child or about this questionnaire, contact the KCSD Registrar: 845–943–3011; registration@kingstoncityschools.org

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to them?	☐ z	☐ v	☐ x	◯ v	____
2. Does your child cling to you more than you expect?	☐ x	☐ v	☐ z	◯ v	____
3. Does your child like to be hugged or cuddled? 	☐ z	☐ v	☐ x	◯ v	____
4. Does your child talk or play with adults they know well?	☐ z	☐ v	☐ x	◯ v	____
5. When upset, can your child calm down within 15 minutes?	☐ z	☐ v	☐ x	◯ v	____
6. Does your child seem too friendly with strangers?	☐ x	☐ v	☐ z	◯ v	____
7. Does your child settle himself/herself down after exciting activities?	☐ z	☐ v	☐ x	◯ v	____
8. Does your child seem happy?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

60 Month Questionnaire

ASQ:SE-2

Check the box ☑ that best describes your child's behavior.
Also, check the circle ◯ in the last column if the behavior is a concern.

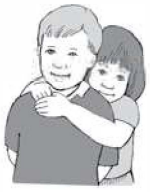
	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Does your child cry, scream, or have tantrums for long periods of time?	☐ x	☐ v	☐ z	◯ v	____
10. Is your child interested in things around them, such as people, toys, and foods? 	☐ z	☐ v	☐ x	◯ v	____
11. Does your child go to the bathroom by himself/herself? (Reminders and help with wiping are okay.)	☐ z	☐ v	☐ x	◯ v	____
12. Does your child have eating problems? For example, do they stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	☐ x	☐ v	☐ z	◯ v	____
13. Does your child stay with activities they enjoy for at least 15 minutes (other than watching shows or videos, or playing with electronics)?	☐ z	☐ v	☐ x	◯ v	____
14. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	◯ v	____
15. Does your child do what you ask them to do? For example, do they wash their hands or wait to take a turn when asked?	☐ z	☐ v	☐ x	◯ v	____
16. Does your child seem more active than other children their age?	☐ x	☐ v	☐ z	◯ v	____
17. Does your child sleep at least 8 hours in a 24-hour period?	☐ z	☐ v	☐ x	◯ v	____
18. Does your child use words to tell you what they want or need?	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

60 Month Questionnaire

ASQ: SE-2

Check the box ☑ that best describes your child's behavior.
Check the circle ◉ in the last column if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
19. Does your child use words to describe his/her feelings and the feelings of others? For example, do they say, "I'm happy," "I don't like that," or "She's sad?"	☐ z	☐ v	☐ x	◯ v	____
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐ z	☐ v	☐ x	◯ v	____
21. Does your child explore new places, such as a park or a friend's home?	☐ z	☐ v	☐ x	◯ v	____
22. Does your child do things over and over and get upset when you try to stop them? For example, do they rock, flap hands, spin, or _____? (Please describe.) _____ _____	☐ x	☐ v	☐ z	◯ v	____
23. Does your child hurt himself/herself on purpose?	☐ x	☐ v	☐ z	◯ v	____
24. Does your child follow rules at home or at child care?	☐ z	☐ v	☐ x	◯ v	____
25. Does your child destroy or damage things on purpose?	☐ x	☐ v	☐ z	◯ v	____
26. Does your child stay away from dangerous things, such as fire and moving cars?	☐ z	☐ v	☐ x	◯ v	____
27. Does your child show concern for other people's feelings? For example, do they look sad when someone is hurt?	☐ z	☐ v	☐ x	◯ v	____
28. Do *other* children like to play with your child? 	☐ z	☐ v	☐ x	◯ v	____

TOTAL POINTS ON PAGE ____

60 Month Questionnaire

ASQ:SE-2™

Check the box ☑ that best describes your child's behavior.
Also, check the circle ◯ in the column if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
29. Does *your child* like to play with other children?	☐ z	☐ v	☐ x	◯ v	____
30. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	◯ v	____
31. Does your child take turns and share when playing with other children?	☐ z	☐ v	☐ x	◯ v	____
32. Does your child wake three or more times during the night?	☐ x	☐ v	☐ z	◯ v	____
33. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	☐ x	☐ v	☐ z	◯ v	____
34. Does your child have simple back-and-forth conversations with you? For example: Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	☐ z	☐ v	☐ x	◯ v	____
35. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	☐ x	☐ v	☐ z	◯ v	____

TOTAL POINTS ON PAGE ____

OVERALL Use the space below for additional comments.

36. Do you have concerns about your child's eating, sleeping, or toileting habits?
If yes, please explain: ◯ YES ◯ NO

37. Does anything about your child worry you? If yes, please explain: ◯ YES ◯ NO

38. What do you enjoy about your child?