



We Inspire. We Educate. We Graduate.
All Students, All of the Time

NEW STUDENT REGISTRATION

Welcome to the Kingston City School District

New students are registered by appointment at the Meagher Administrative Building located at 21 Wynkoop Place, Kingston, NY 12401. The Registrar's office is open from 9:00 a.m. to 3:00 p.m. during the school year and from 9:00 a.m. to 2:00 p.m. throughout the summer. Parents should obtain and complete a registration packet prior to scheduling an appointment. Packets are available at the Registrar's office, at each of our school buildings and on the school website kingstoncityschools.org/register. To schedule an appointment, please call 845-943-3011.

PLEASE NOTE

1. The parent/legal guardian must be present at the time of registration and first visit to school.
2. Once all paperwork is complete and the Registration process is finalized, the Registrar will forward the information to the attending school(s). The school(s) will contact you directly your child's start date.

Required Forms to Complete for Registration:

1. Student Registration Form
2. Request for Records Form – not applicable for kindergarten
3. Health Inventory Form
4. Immunization Form
5. Home Language Questionnaire Form

Questions or to schedule an appointment:
Please call (845) 943-3011.

**INFORMATION ABOUT SPECIAL EDUCATION UPON ENTRY TO SCHOOL
Chapter 434 of the Laws of 2014**

Statute: Section 4402

Effective Date: July 1, 2015

Summary:

This amendment requires school districts to notify every parent or person in parental relation of their rights regarding the referral and evaluation of their child for the purposes of special education services or programs. This notification shall be provided to the parents of all students in the district (with and without disabilities) upon their child's entry into public school. Districts may provide this information to parents by directing them to *A Parent's Guide to Special Education* on the New York State Education Department's (NYSED's) web site, provided that the district includes the name and contact information of the district's Committee on Special Education chairperson or other appropriate special education administrator. NYSED's *A Parent's Guide to Special Education* is available in both English and Spanish.

Statute: Chapter 434 of the Laws of 2014

Section 1. Section 4402 of the education law is amended by adding a new subdivision 8 to read as follows:

8. Upon their child's enrollment or attendance in a public school, such school shall notify every parent or person in parental relation of their rights regarding referral and evaluation of their child for the purposes of special education services or programs pursuant to applicable federal and state laws. Such notification may be provided by directing parents or persons in parental relation to obtain information located on the department's website relating to a parent's guide to special education in New York state for children ages three through twenty-one provided the notification shall also contain the name and contact information for the chairperson of the school district's committee on special education or other individual who is charged with processing referrals to the committee in the district.

Beth Lewis-Jackson - 845-943-3061
Director of Special Education Services
Kingston City School District
blewis@kingstoncityschools.org

Student Name _____, _____ School / Grade _____
Last First

Parent/Guardian Name _____ Phone # _____



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Superintendent of Schools

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Deputy Superintendent for Teaching & Learning

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**

KINGSTON CITY SCHOOL DISTRICT PUPIL REGISTRATION FORM

DATE _____ GRADE _____

Student Name _____ Gender _____ Hispanic? Yes No
(Last) (First) (Middle)

Race (choose all that apply): Asian Black Native American/Native Alaskan Pacific Islander White

Date of Birth _____ Place of Birth (city, state) _____ Country (if not US) _____

Pre K Experience Yes NO

Has pupil ever attended school in this district: Yes _____ No _____

If yes, which school _____ Grade(s) _____

Name of last school attended _____ Grades attended in previous school _____

Address of school last attended _____

Phone/Fax (circle one) (if known) _____ If high school: date entered 9th grade _____

For Immigrant Students and ESL (English as a second language) students ONLY

ESL? Yes No

Date of US Entry: _____ Date First Entered School in US _____

These questions address the McKinney-Vento Act 42 U.S.C. 11435. This information helps determine eligibility for services:

1. Is your current address a temporary living arrangement? Yes No If "No" stop here. If "Yes" please continue:
2. Is your temporary living arrangement due to loss of housing or economic hardship? Yes No

Where is the student presently living?

- In a motel In a shelter With more than one family in a house or apartment Moving from place to place
 In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite.

PARENTS/GUARDIANS WITH WHOM CHILD(REN) RESIDE(S)

Home Phone _____ Unlisted? Yes No Contact Priority _____

Address _____ City _____ State _____ Zip _____

Mailing Address, if different _____

Dominant Home Language _____ ESL YES NO

Resident Type: Lease Own Rent Trailer Park/Condo Unit Unknown

Proof of Residency: Mortgage Statement Property Tax Bill Real Estate Statement Utility Bill

Lease Landlord Verification Form Other _____

INFORMATION TO BE COMPLETED FOR PARENTS/GUARDIANS WHO LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN):

Parent/Guardian Name _____

(Last)

(First)

(Middle)

Relationship _____ Legal custody? YES NO

Cell Phone _____ Contact Priority _____

Work Phone _____ Contact Priority _____

Email Address _____

Employer's Name _____

Employer's Address _____

(City)

(State/Zip)

Currently Serving Active Military Duty YES NO If yes, date enlisted: _____ Date Exited: _____

Parent/Guardian Name _____

(Last)

(First)

(Middle)

Relationship _____ Legal custody? YES NO

Cell Phone _____ Contact Priority _____

Work Phone _____ Contact Priority _____

Email Address _____

Employer's Name _____

Employer's Address _____

(City)

(State/Zip)

Currently Serving Active Military Duty YES NO If yes, date enlisted: _____ Date Exited: _____

INFORMATION TO BE COMPLETED FOR A PARENT/GUARDIAN WHO DOES NOT LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN):

Name _____

(Last)

(First)

(Middle)

Relationship _____

Address _____

Address _____ Correspondence Yes No

(City)

(State/Zip)

Home Phone _____ Contact Priority _____

Cell Phone _____ Contact Priority _____

Work Phone _____ Contact Priority _____

Email Address _____

Currently Serving Active Military Duty YES NO If yes, date enlisted: _____ Date Exited: _____

EMERGENCY CONTACT INFORMATION—OTHER THAN PARENT/GUARDIAN:

Name _____ Gender _____
(Last) (First) (Middle)

Resides in Same Household Yes No

If different household:

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____

Relationship to Student _____

Name _____ Gender _____
(Last) (First) (Middle)

Resides in Same Household Yes No

If different household:

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____

Relationship to Student _____

OTHER CHILDREN WHO RESIDE IN HOUSEHOLD

Children not yet enrolled in school:

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Children enrolled in school:

Name _____ DOB _____ SCHOOL _____

Name _____ DOB _____ SCHOOL _____

Name _____ DOB _____ SCHOOL _____

Guardian Warnings? No Yes Explain _____

Custody Papers? No Yes Explain _____

Information collected by (name of registrar): _____



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)

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

HOME LANGUAGE CODE

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

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: <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:	

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

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

CHECK ALL THAT APPLY TO YOUR CHILD:

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

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	<input type="checkbox"/>	<input type="checkbox"/>	
Taken at home	<input type="checkbox"/>	<input type="checkbox"/>	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other:
TREATMENTS	YES	NO	
During or outside of school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> 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: _____



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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:

Kingston City School District
21 Wynkoop Place
Kingston, NY 12401
845-943-3000

Dear Parents and Guardians,

Welcome to Kindergarten! The information in this form will be used to develop class lists for kindergarten and it will help teachers create a positive learning environment that meets your child's social, emotional and learning needs. We greatly appreciate your thoughtful replies to the following questions:

Child's given name: _____

Child's nickname for school (if any): _____

Has your child attended preschool or daycare? If so, please provide:

Name of preschool or day care provider: _____

Years attended: _____

Number of days per week/hours per day: _____

How does your child react to separation? _____

How does your child react to new situations? _____

Please identify any friends of your child also entering Kindergarten this year in the same school:

What does your child enjoy doing? _____

What are your child's strengths? _____

What does your child find challenging or difficult? _____

Does your child have fears? If so, please explain: _____

Skills- please check if your child can complete tasks successfully

_____dresses him/herself

_____opens snacks and drinks

_____zips zippers

_____puts on coat or jacket

_____buttons

_____asks for help when needed

_____toileting

_____sits and listens to stories

_____helps pick up or clean up

_____shares and plays with other children

Use this space if you wish to share information about family events that may have had a significant impact on your child, for example: birth of a sibling, death in the family, divorce, remarriage, etc.:

Use this space to tell us anything else you would like us to know about your child:

This will be an exciting year! We look forward to getting to know you and your child.