



Kindergarten Registration Packet

Welcome to the Cohoes City School District!

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

Kindergarten Registration is **by appointment only** and occurs at the District's Main Office located at 7 Bevan St Cohoes, NY 12047. Registration for the 2017-2018 School Year will be held on

February 27, 2016- March 3, 2016 during the hours of **8am to 3:30pm.**

Please call (518) 237-4131 ext. 2299 to schedule an appointment

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

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

- Parent/Legal Guardian photo ID.
- Proof of Age (any of the following): Birth Certificate, Passport, or Baptismal Certificate
- Proofs of Residency: A list of acceptable documents can be found on the Proof of Residency form.
- Proof of Immunization and a Physical within the last year: Must be signed or stamped by a State Licensed health care provider. Proof may be faxed to (518)833-7009 directly from the physician's office.
- Custody papers(if applicable)
- Individualized Education Plan(if applicable)

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

Your child is placed in an elementary school dependent upon which school zone you reside.

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

Abram Lansing: (518)237-5044 X3120

Harmony Hill: (518)237-1900 X5222

Van Schaick: (518)237-2828

***Cohoes City School District does not provide transportation.**



Residency Form

Student Name: _____ Parent/Guardian: _____

Physical Address: _____ City/State/Zip: _____

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.

Where is the student currently living? (Please check one box.)

- | | |
|--|--|
| <input type="checkbox"/> In an emergency or transitional shelter
<input type="checkbox"/> With another family or other person due to a loss of housing or economic hardship (sometimes referred to as “doubled-up”)
<input type="checkbox"/> With an adult who is not a parent or guardian or alone without an adult | <input type="checkbox"/> In a hotel/motel
<input type="checkbox"/> In a car, park, bus, train, campsite, public place, abandoned building
<input type="checkbox"/> Other temporary living situation(Please describe):
_____ |
|--|--|

←-----If any of the above are checked please **sign at the bottom and go to Next Page.**-----→

- Student is in permanent housing** (Please continue below if you own, rent or are residing with a district resident)

***When you registrar OR move within the Cohoes City 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 current)

***If an ROP is provided no other proof is necessary.**

If you Own	If you Rent	Reside with a district resident
<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 Drivers’ License <input type="checkbox"/> Utility Bill w/in 30days <input type="checkbox"/> A record of voter registration	<input type="checkbox"/> *Residential Occupancy Permit (ROP) <div style="margin-left: 20px;">➡ Can be obtained from City Hall 518-233-2127, landlord, or a form can be signed at the time of registration.</div> <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 with landlords name and phone number) <input type="checkbox"/> Current Renter’s Insurance	<input type="checkbox"/> Notarized letter from the district resident <u>along with the resident’s proof of ownership (house deed, tax bill, or mortgage statement).</u> *A residency check will be done by a school representative as well. -----Office Use ----- Date of HV: _____ <input type="checkbox"/> Verified <input type="checkbox"/> Not Verified

Once this form is received by the District Registrar residency will be verified.

Print: _____ Signature: _____ Date: _____
Parent, Guardian, or Student (unaccompanied homeless youth) Parent, Guardian, or Student



Kindergarten Registration Form

Registration Date: _____

Student Information

Student's Name: _____

First
Middle
Last

Birth Date: _____ Age: _____ Gender: Male Female Grade: K

Home Phone: _____

Residential Address: _____

Street
Apt# or Floor

City
State
Zip

Mailing Address (if different than above): _____

Has your child previously attended Cohoes CSD?
 Yes No

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

1.) **Ethnicity** – *Check those which apply.*
 Hispanic Not Hispanic

2.) **Race** – *Check all those which apply.*
 American Indian or Alaska Native Asian
 Black or African-American White
 Native Hawaiian or other Pacific Islander

Parent/Guardian Information

Student Resides With: Parents Mother Father Foster Parents (please attach form DSS-2999) Other: _____

Are there Legal Arrangements? No Yes (if yes, please provide court documents) | Joint Custody Sole Custody Temporary Custody Visitation

Primary Parent/Guardian Name: _____ Relationship to child: _____ Active Military: Yes No

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

E-Mail Address: _____

Parent/Guardian Name: _____ Relationship to child: _____ Active Military: Yes No

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

E-Mail Address: _____

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

Household Information

List all <u>Children</u> residing at residence	Gender	Birthdate	Grade	School

-----Go on to next page-----

For Office Use Only

Documents provided to the district:

- | | | |
|---|---|---|
| <input type="checkbox"/> Photo ID
<input type="checkbox"/> Birth Certificate
<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Physical
<input type="checkbox"/> Dental Certificate
NOTES: | Proof of Residency:
<input type="checkbox"/> Deed or Tax Bill
<input type="checkbox"/> Utility bill
<input type="checkbox"/> Driver's License
<input type="checkbox"/> ROP
<input type="checkbox"/> Cohoes Housing Authority
<input type="checkbox"/> Notarized letter and home visit
<input type="checkbox"/> Other _____
<input type="checkbox"/> Signed Lease <input type="checkbox"/> STAC <input type="checkbox"/> Free/Reduced | Custody Papers:
<input type="checkbox"/> DSS 2999
<input type="checkbox"/> Custody |
|---|---|---|

Student ID # _____

Grade: _____ VS AL HH MS HS

Referrals: CSE ELL

Stamp Date: _____

Registrar Signature: _____



Kindergarten Registration Form

Emergency Contact

Name: _____	Relationship to child: _____
Home Phone: _____	Work Phone: _____
Cell Phone: _____	
Name: _____	Relationship to child: _____
Home Phone: _____	Work Phone: _____
Cell Phone: _____	
Name: _____	Relationship to child: _____
Home Phone: _____	Work Phone: _____
Cell Phone: _____	

Special and/or Medical Needs

Please check any services that your child receives:

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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Declassified	<input type="checkbox"/> I Don't Know
Physical Therapy	<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
Behavior	<input type="checkbox"/> No	<input type="checkbox"/> Diagnosed: _____	<input type="checkbox"/> Concerns: _____	
Emotional	<input type="checkbox"/> No	<input type="checkbox"/> Diagnosed: _____	<input type="checkbox"/> Concerns: _____	

Has your child previously attended preschool? No Yes (If yes please list the school (s) below)

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

Photo Release

Yes No I hereby grant the Cohoes City 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 a fictitious name. I understand this will be for the purpose of illustration, promotion, and public relations of school programs and may appear in printed material, video presentation, news coverage (both print and television) and/or on the district's web site.

Student Record Updates

It is very important that the school district receive updates to any of the information provided in this Student Registration Packet. Please contact the school your student is attending with new or changed information and submit the Change of Information form, which can be found at www.cohoes.org or at your child's school, with supporting documents.

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



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 conduct 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.

***Both the Health Appraisal Form and Dental Certificate can be printed from www.cohoes.org/studentregistration.**

Thank you for your cooperation in this new health endeavor. 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
___Animals
___Bees
___Food: _____
___Medications: _____
___Seasonal
___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 Disabilities
<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 Disorders
<input type="checkbox"/> Serious Injuries
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Vision Problems
Last Vision Exam: _____
Glasses: ___Yes ___No |
|--|--|--|--|

Other Health Issue: _____

Comments: _____

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

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 the child 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.

It is essential that we maintain the safety of your child while he/she is in school, especially with regard to emergency and/or chronic medical condition(s). The medical condition(s) must be confirmed in writing. Medical condition information will only be shared with staff members who interact with your child. Any written information will be kept inaccessible to maintain privacy.

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 Medic-Alert information.

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

Abram Lansing: Sandra Tessier, 237-5044 Ext. 3104
Harmony Hill: Lisa Leblanc, 233-1900, Ext. 5225
Van Schaick: Rachel Marer, 237-2828, Ext. 4106

Cohoes Middle School: Cheryl Barber, 237-4131, Ext. 2111
Cohoes High School: Alexandra Beaury, 237-9100, Ext. 1410

 Parent/Guardian Signature

 Date



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:		

First	Middle	Last
_____	_____	_____
DATE OF BIRTH:		GENDER:
Month	Day	Year
_____	_____	_____
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?	<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>	<i>specify</i>
	<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:
Cohoes City School District (010500010000)	_____
7 Bevan St Cohoes, NY 12047	_____
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* <input type="checkbox"/>	No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past?	
<input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply):	
<input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____	

_____ <i>Signature of Parent or of Person in Parental Relation</i>	Month: _____	Day: _____	Year: _____
Date			
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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:	