



## 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.

Registration for all children entering the Cohoes City School District is **by appointment only** and occurs at the District's Main Office located at **7 Bevan St Cohoes, NY 12047**. You can 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
- (2) Proofs of residency:** A list of acceptable documents can be found on the Proof of Residency form.
- Proof of Immunization and a Physical:** 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) and Academic Records**  
*\*All academic records must be received from previous school before a HS schedule can be made.*

*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:

<u>Elementary Schools</u>	<u>Middle School</u>	<u>High School</u>
Abram Lansing: (518)237-5044 X3120 Harmony Hill : (518)237-1900 X5222 Van Schaick : (518)237-2828 X4116	Cohoes Middle School: (518)237-4131 X2227	Cohoes High: (518)237-9100 X1425
<i>Arrival- 8:50AM</i> <i>Dismissal- 2:40 PM</i>	<i>Arrival-8:15 AM</i> <i>Dismissal- 2:36 PM</i>	<i>Arrival-8 AM</i> <i>Dismissal- 2:24 PM</i>



## Residency Questionnaire

Student Name: \_\_\_\_\_ Gender: M F Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

### 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 don't 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 describe): \_\_\_\_\_
- Student is in permanent housing**

If 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: \_\_\_\_\_ Date: \_\_\_\_\_  
*Parent, Guardian, or Student (unaccompanied homeless youth) Parent, Guardian, or Student*



## Residency Form

Parent/Guardian: _____	Student(s) Names: _____ Grade: _____
Relationship to student(s): _____	_____ Grade: _____
Physical Address: _____	_____ Grade: _____
City/State/Zip: _____	_____ Grade: _____

Please check one:    Own    Rent    Reside 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.**

*To enroll you must reside in the school district. Solely owning property or a home does not constitute residency.*

### 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"/> Cohoes Housing Authority	<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 and documents is received by the District, residency will be verified.**

Parent/Guardian Signature	Date	Approved by: Signature	Date
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## Student Registration Form

Registration Date: \_\_\_\_\_

### Student Information

Student's Name: \_\_\_\_\_  
First                      Middle                      Last

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female Grade: \_\_\_\_\_

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

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

Student ID # \_\_\_\_\_

Grade: \_\_\_\_\_  VS  AL  HH  MS  HS

Referrals:  CSE  ELL

Stamp Date: \_\_\_\_\_

Registrar Signature: \_\_\_\_\_



## Student Registration Form

### Emergency Contact

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell 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	<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
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** (*List most recent first*)

Please list all previous schools attended, including preschool: (*if more space is needed, attach additional pages*)

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

### 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](http://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



## Authorization for Release of Records/Information

Date of Request \_\_\_\_\_

### Student Information

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.  
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 documents should be sent to -**

**CSE office (F) 518-237-2532 or Transfer via IEP Direct**

- ✓ Individualized Educational Plan (IEP)
- ✓ Psychological

If the box is checked below, please provide the following  
documents via fax to: **Registrar (F) 518-833-7009**

- Immunization and Health Records and Birth Certificate

### SEND RECORDS TO:

- Abram Lansing Elementary**  
26 James St, Cohoes, NY 12047  
(P) 518-237-5044  
(F) 518-237-1879
- Harmony Hill Elementary**  
Madelon K Hickey Way, Cohoes, NY 12047  
(P) 518-233-1900  
(F) 518-237-1964
- Van Schaick Elementary**  
150 Continental Ave, Cohoes, NY 12047  
(P) 518-237-2828  
(F) 518-237-3597
- Cohoes Middle School**  
7 Bevan St, Cohoes, NY 12047  
(P) 518-237-4131  
(F) 518-237-7127
- Cohoes High School**  
Tiger Circle, Cohoes, NY 12047  
(P) 518-237-9100  
(F) 518-237-7410
- CSE Office \*\*\*Special Education\*\*\*\***  
21 Page Ave, Cohoes, NY 12047  
(P) 518-237-0990  
(F) 518-237-2532



## Student Registration Form

**New York State Education Law requires all NEW ENTRANTS and students in Pre-K or K, 2nd, 4th, 7th and 10<sup>th</sup> 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](http://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, <i>date:</i> _____ <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, <i>date:</i> _____ <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
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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.

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*



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.		
<b>STUDENT NAME:</b>		
_____		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
_____		<input type="checkbox"/> Male
Month	Day	Year
_____		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
_____		
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:**

Cohoes City School District (010500010000)

District Name (Number) & School

7 Bevan St  
Cohoes, NY 12047

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:

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*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: _____ Mo.   DAY   YR.	<table style="width: 100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <b>OUTCOME OF INDIVIDUAL INTERVIEW:</b> </td> <td style="border: none;"> <input type="checkbox"/> ADMINISTER NYSITELL  <input type="checkbox"/> ENGLISH PROFICIENT  <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM                 </td> </tr> </table>	<b>OUTCOME OF INDIVIDUAL INTERVIEW:</b>	<input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
<b>OUTCOME OF INDIVIDUAL INTERVIEW:</b>	<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: _____ Mo.   DAY   YR.	<table style="width: 100%; border: none;"> <tr> <td style="border: none; vertical-align: top;"> <b>PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</b> </td> <td style="border: none;"> <input type="checkbox"/> ENTERING   <input type="checkbox"/> EMERGING   <input type="checkbox"/> TRANSITIONING   <input type="checkbox"/> EXPANDING   <input type="checkbox"/> COMMANDING                 </td> </tr> </table>	<b>PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</b>	<input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
<b>PROFICIENCY LEVEL ACHIEVED ON NYSITELL:</b>	<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:			