SYRACUSE CITY SCHOOL DISTRICT

Early Childhood Programs
1005 W. Fayette St.-4th Floor · Syracuse, NY 13204
Phone 315·435·4276 · Fax 315·435·6553

Jaime Alicea
Interim Superintendent of Schools

Please Print

2017 – 2018 Pre-Kindergarten Registration
NEW STUDENT Application Checklist

____ ____________________

Child's Last Name, First Name & Middle Initial — Date of Birth

4 Year Old *(12/2/12 - 12/1/13)*	**Please circle one**	3 Year Old* *(12/2/13 – 12/1/14)*

Must be 3 or 4 by December 1, 2017

**Some Three Year Olds will be placed mid-October based on available space.*

SCSD Home School: ____

Notes: ____

PARENT/GUARDIAN PLACEMENT PREFERENCES

Choice 1)		***Session (please circle):***	AM	PM	Full Day	Any
Choice 2)		***Session (please circle):***	AM	PM	Full Day	Any
Choice 3)		***Session (please circle):***	AM	PM	Full Day	Any

REQUIRED ITEMS

Parent/guardian must ***complete***:

- ☐ SCSD Application (Online / Paper)
- ☐ Home Language Questionnaire (HLQ)
- ☐ City School District Health History
- ☐ Health Information Authorization

Parent/guardian must ***provide***:

- ☐ Child's Proof of Birth
- ☐ Proof of City Residency (1 form)
- ☐ Immunization record from doctor
- ☐ Physical Examination (within 1 calendar year)

PLACEMENT INFORMATION

School/Agency Site:					
Classroom/Teacher Info:					
Session (Please circle one):	**AM**	**PM**	**Full Day**	***Start Date:***	
Agency Delivery Date:		***Delivered by:***			
Agency Program Type (Please circle one):	**UPK**	**EPK**	**SWUFD**	**3PK**	

SCSD Staff Use Only:

Date all application items received:		***SCSD Staff Initials:***	

****Please submit all materials to the address listed above****

White: Application Copy — Yellow: Pre-K Registration Copy — Pink: Parent/Guardian Copy

Syracuse City School District

REGISTRATION FORM

PLEASE PRINT * PLEASE PRINT*

STUDENT ID# ______________________ (Office Only)

STUDENT NAME ____ SEX: ______
(Last) (First) (Middle) (Jr / Sr / III / IV) (M / F)

BIRTH DATE __________________ BIRTHPLACE ______________________________
(MM/DD/YYYY) (City, State, Country)

US CITIZEN ________ If no, indicate citizenship ______________ US Entry Date __________ PASSPORT # __________ Primary Language ____________
(Yes / No)

EVER ATTEND NYS SCHOOL ______ If yes, Indicate School / Yr ______________

EVER ATTEND A Syracuse SCHOOL ______ If yes, Indicate School / Yr ______________

Hispanic - YES ____ No ____

Please check one or more from below

- ___ AMERICAN INDIAN OR ALASKA NATIVE
- ___ ASIAN
- ___ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ___ BLACK OR AFRICAN AMERICAN
- ___ WHITE

LAST SCHOOL ATTENDED

DISTRICT ______________________

ADDRESS ______________________

Phone# ______________________

DATE LEFT __________ CURRENT GRADE __________

STUDENT RESIDENTIAL ADDRESS

STREET ______________________ APT # ______

CITY ______________________

STATE __________ ZIPCODE __________

HOME or CELL PHONE ______________________

STUDENT MAILING ADDRESS (only if different than Residential)

STREET ______________________ APT # ______

CITY ______________________

STATE __________ ZIPCODE __________

Where is the student currently living? (Please check <u>one</u> box)

1. ☐ In a shelter (S)
2. ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up") (D)
3. ☐ In a hotel/motel (H)
4. ☐ In a car, park, bus, train, or campsite (U)
5. ☐ Awaiting Foster Care (A)
6. ☐ Other temporary living situation (T)
   (Please describe): ______________________
7. ☐ In Permanent housing

If you checked 1-6, are you also an unaccompanied youth? ("Unaccompanied" means that you are not currently living with a parent/guardian) ☐ Yes ☐ No

Your answers will help the district determine what services your child may be able to receive under the McKinney-Vento Act. Please ask for the McKinney-Vento liaison for additional information.

GUARDIAN

NAME ____
(Mr/Ms) (First) (Middle) (Last) (Jr / Sr / III / IV)

STREET ______________________________ Apt # ______

CITY ______________ STATE __________ ZIP __________

HOME PH __________ WORK PH __________ WORK PH 2 __________

CELL PH __________ PAGER __________ CELL PH 2 __________

EMAIL ADDRESS ______________ RELATIONSHIP TO STUDENT: __________

PLACE & ADDRESS OF EMPLOYMENT ______________________________

Receive Mailings YES / NO

Relationship to Student __________

Living with Student YES / NO

GUARDIAN

NAME ____
(Mr/Ms) (First) (Middle) (Last) (Jr / Sr / III / IV)

STREET ______________________________ Apt # ______

CITY ______________ STATE __________ ZIP __________

HOME PH __________ WORK PH __________ WORK PH 2 __________

CELL PH __________ PAGER __________ CELL PH 2 __________

Receive Mailings YES / NO

Relationship to student __________

Living with Student YES / NO

If there are any custody restrictions of which we should be made aware, please provide.

(PLEASE TURN OVER AND COMPLETE BACK OF FORM)

Rev. 5/1/12

EMAIL ADDRESS ______________________ RELATIONSHIP TO STUDENT: ______________

PLACE & ADDRESS OF EMPLOYMENT ______________________

If Student is not living with both parents, with whom is student living? ______________

Does this person have legal custody of the student? ______________

EMERGENCY CONTACT

NAME ______________________
(Mr/Ms) (First) (Middle) (Last) ((Jr / Sr / III / IV)

STREET ______________________ APT # __________

CITY ______________ STATE __________ ZIP __________

HOME PH __________ WORK PH __________ WORK PH 2 __________

CELL PH __________ PAGER __________ CELL PH 2 __________

RELATIONSHIP TO CHILD ______________________

PLACE & ADDRESS OF EMPLOYMENT ______________________

EMERGENCY CONTACT

NAME ______________________
(Mr/Ms) (First) (Middle) (Last) ((Jr / Sr / III / IV)

STREET ______________________ APT # __________

CITY ______________ STATE __________ ZIP __________

HOME PH __________ WORK PH __________ WORK PH 2 __________

CELL PH __________ PAGER __________ CELL PH 2 __________

RELATIONSHIP TO CHILD ______________________

PLACE & ADDRESS OF EMPLOYMENT ______________________

CHILDCARE PROVIDER: __________ __________ __________
(Name) (Address) (Phone)

OTHER CHILDREN IN FAMILY

NAME ______________ (First) (Middle) (Last) BUILDING __________ SEX: _____ (M / F) DOB __________ (MM/DD/YYYY) AT RESIDENCE _______ (Yes /No)

NAME ______________ (First) (Middle) (Last) BUILDING __________ SEX: _____ (M / F) DOB __________ (MM/DD/YYYY) AT RESIDENCE _______ (Yes /No)

NAME ______________ (First) (Middle) (Last) BUILDING __________ SEX: _____ (M / F) DOB __________ (MM/DD/YYYY) AT RESIDENCE _______ (Yes /No)

NAME ______________ (First) (Middle) (Last) BUILDING __________ SEX: _____ (M / F) DOB __________ (MM/DD/YYYY) AT RESIDENCE _______ (Yes /No)

NAME ______________ (First) (Middle) (Last) BUILDING __________ SEX: _____ (M / F) DOB __________ (MM/DD/YYYY) AT RESIDENCE _______ (Yes /No)

NAME ______________ (First) (Middle) (Last) BUILDING __________ SEX: _____ (M / F) DOB __________ (MM/DD/YYYY) AT RESIDENCE _______ (Yes /No)

OTHER PERSONS LIVING IN THIS RESIDENCE

NAME ______________________ RELATIONSHIP ______________

NAME ______________________ RELATIONSHIP ______________

STUDENT EMERGENCY INFORMATION

PHYSICIAN ______________ PHONE __________ HOSPITAL CHOICE __________

SPECIAL SERVICES

ANY DISABILITIES _______ (Yes/No) If yes, specify ______________ ESL _______ 504 _______ (Yes/No) CSE _______ (Yes/No) CPSE _______

*** IMMUNIZATION RECORDS REQUIRED TO ENTER SCHOOL** (<u>This is not a pre-requisite for students experiencing homelessness</u>)

Additional Information: ______________________

____

____

Signature of Parent/Guardian ______________________ **Date** __________

Signature of School Official who registered child ______________________ **Date** __________

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-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:

Month | Day | Year

GENDER:
❑ 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.)

Question			
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 ❑ Guardian(s) ________ specify	❑ Father ________ 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

SYRACUSE CITY SCHOOL DISTRICT HEALTH HISTORY FORM

Name of Student: ______________________ D.O.B.__________ Sex M ☐ F ☐

Today's Date ______________ School ______________________ Grade ________

Has this child ever attended a Syracuse City School? No ☐ Yes ☐ School attended ______________________

Parent/Guardian Name ______________ Address ______________________ Phone# __________

Doctor's Name ______________________________ When was last visit? __________

Dentist's Name ______________________________ When was last visit? __________

Insurance ______________ Medicaid # ______________ SSI# __________

Pregnancy & Delivery: Birth weight ______# ______oz. Length of pregnancy ______weeks Labor: ______hrs

Type of delivery ☐ Vaginal ☐ C–section Complications? ______________________

Growth and Development *Please fill in age at which your child*

Sat up ________ Crawled ________ Walked ________ Talked ________ Toilet Trained ________

Please give a brief description of the following regarding your child:

Medications: ______________________ Allergies: ______________________

Serious Illnesses: ____

Accidents: ______________________________ Date(s): __________

Surgeries/Hospitalizations/ER Visits ______________________ Date(s): __________

Has your child had any problems with? Please explain in the space below.

☐ Asthma Diagnosis	☐ Eye Problems/glasses	☐ Seizures
☐ Blood Disorder/Sickle Cell	☐ Heart Problems	☐ Skin rashes
☐ Chicken Pox	☐ Hepatitis ☐A or ☐B	☐ Speech Problems
☐ Ear Problems	☐ Increased lead levels	☐ Tuberculosis
☐ Emotional Problems	☐ Limitations on activities	☐ Other medical condition

Please explain any of the above or add additional information that will help us to help your child.

____

____

____

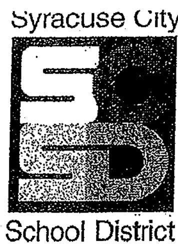
____

Special equipment/supplies needed ______________________________

Are there any major health problems of any other family members? Explain. ______________________

____

COPY AND ATTACH IMMUNIZATION RECORD TO BACK OF FORM



SYRACUSE CITY SCHOOL DISTRICT

Health Services
725 Harrison Street · Syracuse, NY 13210
Phone 315·435·4145 · Fax 315·435·4859

Jaime Alicea
Interim Superintendent of Schools

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: ______________________ DOB: __________ Date: __________

As the parent/guardian of the child named, the completion of this form authorizes your doctor, ____________________ to disclose your child's confidential health-related information to his or her school.
(Name of Doctor)
The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the child's school. This is important information for many reasons. For example the school may need to know this information in order to give medications, monitor the child's illness, and keep track of immunizations.

This authorization limits the disclosure of information to the following:

- ☐ Immunization information
- ☐ Physical exam reports
- ☐ Laboratory tests
- ☐ Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.

The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child's information to their school. The child's healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. You will be given a copy of this completed authorization to keep for your records.

______________________ ______________________
Child's Name (print) Date of Birth

______________________ ______________________
Parent/Guardian's Name (print) Relationship

______________________ ______________________
Parent/Guardian's Signature School

Please return to School Nurse.

M:\ REVISED MEDICAL FORMS\Authorization for Disclosure of Health Info-Student printshop copy.doc