

# **Kindergarten Parent Information Night**

**Tuesday, April 20<sup>th</sup> 6:00 – 7:00 pm**  
**via Zoom**

<https://zoom.us/j/96888649842?pwd=Qy8zNmpDeDI2cEwybzdoMytsWlhFQT09>

*The Parent Input Form and other important information that will be addressed at this meeting, will be made available on the VECS website or for pick up at the VECS Main Office starting Monday, April 12<sup>th</sup>*

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## **Multi-Age Parent Information Presentation**

**Tuesday, April 27<sup>th</sup> at 7:15 pm via Zoom**

<https://victorcentralschools-org.zoom.us/j/7480688065>

**NOTE TO SCHOOLS/LEAS:** Please assist students and families filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

**ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE**

Name of School District: \_\_\_\_\_

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_  
Last First Middle

Gender: Male Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_ ID#: \_\_\_\_  
Female Month Day Year (preschool-12) (optional)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

The answer 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 the 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 a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): \_\_\_\_\_
  
- In permanent housing

\_\_\_\_\_  
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

\_\_\_\_\_  
Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

\_\_\_\_\_  
Date

If the student is **NOT** living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

**NOTE TO SCHOOLS/LEAS:** If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

# VICTOR CENTRAL SCHOOL DISTRICT

## Student Registration Form

**FOR OFFICE USE ONLY**

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

Grade \_\_\_\_\_

### STUDENT INFORMATION

Name \_\_\_\_\_ Preferred Name (if applicable) \_\_\_\_\_

FIRST MIDDLE LAST

Mailing Address \_\_\_\_\_

CITY STATE ZIP

Home Address \_\_\_\_\_

(if different from mailing address) CITY STATE ZIP

Home Phone: ( ) Cell Phone: ( )

County of Residence:  Ontario  Wayne  Monroe

Birth Date: \_\_\_/\_\_\_/\_\_\_ Gender:  M  F

Who does the child live with?  Mother  Father  Step-Mother  Step-Father  Legal Guardian  Foster Parent  
 Mother  Father  Step-Mother  Step-Father  Legal Guardian  Foster Parent

### SCHOOL RECORDS

Name of School Last Attended \_\_\_\_\_ District \_\_\_\_\_

Street Address \_\_\_\_\_

CITY STATE ZIP

Phone: ( ) Guidance Office Fax Number: ( )

### STUDENT SERVICES

Has your child ever been identified as having an educational disability?  Yes  No

If yes, please describe \_\_\_\_\_

Check which applies:  Student has a current Individualized Education Plan (IEP)

Student has a 504 Accommodation Plan

Please describe any Special Education Services that your child has received (i.e. speech, occupational therapy, physical therapy, resource, special class, remedial instruction): \_\_\_\_\_

Has your child received any other services (i.e. gifted/talented and/or English as a Second Language)?

Yes  No If so, please describe \_\_\_\_\_

Are there any significant health problems?  Yes  No

Please specify:  Asthma  Allergies  Diabetes  Seizures  Other \_\_\_\_\_

Student's Name \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

- Mother  Father  Step-Mother  Step-Father
- Legal Guardian  Foster Parent

Name \_\_\_\_\_

Address \_\_\_\_\_  
*(if different from child's)*

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

E-Mail Address \_\_\_\_\_

- Mother  Father  Step-Mother  Step-Father
- Legal Guardian  Foster Parent

Name \_\_\_\_\_

Address \_\_\_\_\_  
*(if different from child's)*

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

E-Mail Address \_\_\_\_\_

- Mother  Father  Step-Mother  Step-Father
- Legal Guardian  Foster Parent

Name \_\_\_\_\_

Address \_\_\_\_\_  
*(if different from child's)*

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

E-Mail Address \_\_\_\_\_

- Mother  Father  Step-Mother  Step-Father
- Legal Guardian  Foster Parent

Name \_\_\_\_\_

Address \_\_\_\_\_  
*(if different from child's)*

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Are there any custodial restrictions or an order of protection? Please explain: \_\_\_\_\_

**EMERGENCY CONTACTS** *(beyond parent/legal guardian)*

Name \_\_\_\_\_

Relationship to Child:

- Grandparent  Neighbor  Sitter  Other

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Name \_\_\_\_\_

Relationship to Child:

- Grandparent  Neighbor  Sitter  Other

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

**SIGNATURE**

Verification By Subscription And Notice Under Penal Law Section 210.45

It is a crime punishable as a Class A Misdemeanor under the laws of the State of New York, for a person, in and by a written instrument, to knowingly make a false statement, or to make a statement, which such person does not believe to be true.

Affirmed under penalty of perjury this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Signature \_\_\_\_\_

Victor Central Schools Transportation Department  
953 High Street  
Victor, New York 14564  
585-924-3252 Ext. 7120

**ACTION REQUIRED BY JUNE 1, 2021**

In order for us to make the appropriate decisions regarding bus routes, we must have this completed form returned to the Victor Transportation Office by **Tuesday, June 1, 2021**. Please fill this form out every year so all contact information is updated.

THIS FORM MAY BE EMAILED TO KELLY CLINK @ [Clinkk@victorschools.org](mailto:Clinkk@victorschools.org)

**If any changes occur throughout the year** (such as address, phone number or sitter information) please notify the school and the Transportation Department in writing 24 hours in advance.

**This form is required for every student entering grades K-6!!!**

Today's Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Entering Grade for 2021/2022 \_\_\_\_\_

Student Name \_\_\_\_\_  
Last First MI

Parent/Guardian Names \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City/Town Zip Code

Mailing Address (if different) \_\_\_\_\_  
Street City/Town Zip Code

Home phone \_\_\_\_\_ Cell \_\_\_\_\_  
Contact 1 Contact 2

Email address \_\_\_\_\_  
Contact 1 Contact 2

Work phone \_\_\_\_\_  
Contact 1 Contact 2

**AM BUS PICK UP LOCATION**

**PM BUS DROP OFF LOCATION**

Monday \_\_\_\_\_

Monday \_\_\_\_\_

Tuesday \_\_\_\_\_

Tuesday \_\_\_\_\_

Wednesday \_\_\_\_\_

Wednesday \_\_\_\_\_

Thursday \_\_\_\_\_

Thursday \_\_\_\_\_

Friday \_\_\_\_\_

Friday \_\_\_\_\_

Name of Childcare Provider \_\_\_\_\_  
Relationship to student: Sitter, Relative, Neighbor, etc.

Address \_\_\_\_\_  
Street City/Town Zip Code

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

# VICTOR CENTRAL SCHOOL DISTRICT

## STUDENT RACIAL AND ETHNIC IDENTIFICATION FORM

(To be completed post-enrollment)

To the Parent/Guardian: The U.S. Department of Education and the New York State Department require the collection and recording of the racial and ethnic identity of students. The information will be used to:

- Report required data to the State and Federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academics performance, attendance and completion of school.

This information will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

Student's Name: \_\_\_\_\_

### DIRECTIONS TO PARENT/GUARDIAN

PLEASE ANSWER QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) check (✓) the box that best describes your child.]

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

- YES, Hispanic  
 NO, not Hispanic

2. Select one or more races from the following five racial groups [For question (2) check (✓) all groups that apply to your child; check (✓) at least ONE box.]:

- AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original people of North America and South America (including Central America), and who maintains tribal affiliation or community recognition.
- ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- BLACK:** A person having origins in any of the black racial groups of Africa.
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

\_\_\_\_\_  
(Signature of Parent/Guardian/Other)

\_\_\_\_\_  
(Date)

Relationship to Student (Please check one box below):

- Mother     Father     Legal Guardian     Other (Specify): \_\_\_\_\_

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition, or immigration status.



Elisa Alvarez, Associate 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 Person in Parental Relation:  
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.

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

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"/> Parent 1	<input type="checkbox"/> Parent 2	_____
	<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:**

<b>SCHOOL DISTRICT INFORMATION:</b>	<b>STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:</b>
_____	_____
<i>District Name (Number) &amp; School:</i>	<i>Address:</i>

## 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:  Parent  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.	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: _____ MO. DAY YR.	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:	



Victor Central School District  
 Committee on Special Education  
 Pupil Personnel Services  
 953 High St.  
 Victor, NY 14564 ((585) 924-3252 x 1451)

Medicaid Consent

Client Identification Number (CIN): \_\_\_\_\_

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP).

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, \_\_\_\_\_ as the parent/guardian of \_\_\_\_\_, have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

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