KINGSTON
CITY SCHOOL DISTRICT

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 at: **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.

Attachment

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

Statute: Section 4402

Effective Date: July1,2015

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 # _____

KINGSTON
CITY SCHOOL DISTRICT

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

Dr. Paul J. Padalino
Superintendent of Schools

CHECKLIST FOR 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 a physician/medical practice.**

☐ **Custody/Guardian Papers: Necessary in the case of divorce, re-marriage or transfer of** guardianship between family members.

☐ **Parent or Guardian photo identification**: Driver's License, Passport, State ID

☐ **School Records**
For Students who already have attended another school:
1. Copy of most recent report card
2. Transcript if available (Does not apply to kindergarten registration)
   For Special Ed. Students: Most recent copy of IEP (Individualized Education Plan)

☐ **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, oil) 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. If you are living with a relative, that person must complete the form and also provide 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 STUDENT – 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): _____

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

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.

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.)

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*	❑ Father *specify*	❑ Guardian(s) *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: *District Name (Number) & School* *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: _____
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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Kingston City School District

HEALTH HISTORY for REGISTRATION & ATHLETES

Please complete in blue or black ink.

Name:	DOB: Age:	Gender: ☐ M ☐ F
School:	Grade:	
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition/medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization/Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Cardiac History:	**YES**	**NO**	**If Yes, please specify:**
Has anyone in your immediate family had any serious cardiac history such as: heart attack or sudden cardiac death under the age of 50, irregular heart beat, pacemaker, cardiomyopathy, structural defects, genetic heart defects	☐	☐	
Has your student had any irregular heartbeats, symptoms during or after exercise, fainting	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

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

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

KINGSTON
CITY SCHOOL DISTRICT
We Inspire. We Educate. We Graduate.
All Students. All of the Time

Request for Records

Please be advised that my child, _____ who was previously enrolled in your school has transferred to the Kingston City School District. I hereby authorize you to send the following information for my child to the school marked below: complete records of academic work (*including all high school level Science labs), health records, the last day of attendance, attendance data, standardized test results, guidance information, psychological reports and all other information that is considered to be part of the child's permanent record.

Student Date of Birth:		
Parent/Guardian Signature:		
Name of Previous School:		
• **Street Address:**		
• **City, State and Zip:**		
School Phone #:		
School Fax #:		
Does your student have an IEP - Individualized Education Program?	☐ Yes* ☐ No	***IF YES, please send a duplicate copy of records and IEP with all evaluations to the KCSD Special Education Department (Address below)**

Please send and/or fax records to the school indicated below

___ **Chambers Elementary School** 945 Morton Boulevard Kingston, NY 12401-1399 Phone: (845) 943-3392 Fax: (845) 336-5616	___ **Edward R. Crosby Elementary School** 767 Neighborhood Road Lake Katrine, NY 12449-5337 Phone: (845) 943-3333 Fax: (845) 382-2668
___ **Harry L. Edson Elementary School** 116 Merilina Avenue Extension Kingston, NY 12401-4226 Phone: (845) 943-3362 Fax: (845) 331-9034	___ **Robert Graves Elementary School** PO Box 549 345 Mountain View Rd. Port Ewen, NY 12466-0549 Phone: (845) 943-3422 Fax: (845) 338-3049
___ **John F. Kennedy Elementary School** 107 Gross Street Kingston, NY 12401-5598 Phone: (845) 943-3102 Fax: (845) 331-2477	___ **Ernest C. Myer Elementary School** 121 Schoolhouse Road Hurley, NY 12443-5231 Phone: (845) 943-3484 Fax: (845) 331-1520
___ **George Washington Elementary School** 67 Wall Street Kingston, NY 12401-4854 Phone: (845) 943-3513 Fax: (845) 338-3041	___ **M. Clifford Miller Middle School** 65 Fording Place Road Lake Katrine, NY 12449-5221 Phone: (845) 943-3638 (Guidance) Fax: (845) 382-6069
___ **J. Watson Bailey Middle School** 118 Merilina Avenue Extension Kingston, NY 12401-4225 Phone: (845) 943-3572 (Guidance) Fax: (845) 943-3240	___ **Kingston High School** 403 Broadway Kingston, NY 12401-4617 Phone: (845) 943-3970 Fax: (845) _____ Guidance Counselor: _____

*___ For students with IEP's, send duplicate copy of records and IEP with all evaluations:
KCSD Special Education Department
21 Wynkoop Place
Kingston, NY 12401
Phone: (845) 943-3073; Fax: (845) 943-3213

KINGSTON
CITY SCHOOL DISTRICT

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

Dr. Paul J. Padalino
Superintendent of Schools

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)

_____
(Print Name)

Sworn to before me on this
_____ Day of _____, 20_____

_____
(Notary Public)
State of:
County of:

Kingston City School District
Committee on Special Education
21 Wynkoop Pl
Kingston, NY 12401
845-943-3000

Medicaid Consent

RE:
DOB:
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) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

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

I, _____ as the parent/guardian of _____, have received a written notification from the school district/county 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/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or 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 and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

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

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

Student's CIN, if known: _____

___ I do not give consent to bill the Medicaid Insurance Program for special education and related services that are on my child's individualized education program (IEP). Regardless of my decision to deny consent, all required services in my child's IEP will be provided at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____