

CHESTER UNION FREE SCHOOL DISTRICT
STUDENT REGISTRATION

PROOF OF RESIDENCY

One (1) document from Group A. All documents must show your name and Chester School District eligible address. P.O. Box addresses are not accepted as proof of residency.

GROUP A:

- Deed to property
- Mortgage agreement/statement
- Residential Lease with current rent receipt
- A notarized statement from a Landlord or Owner regarding your tenancy
- Temporary shelter proof

A sworn notarized statement from a third party that establishes your residence in the Chester Union Free School District. This must include whether or not you are paying rent or utilities.

SUPPLEMENTARY PROOF OF RESIDENCY

Three (3) documents from Group B. All documents must show your name and Chester School District eligible address. You may submit any other relevant evidence you wish to, including but not limited to the following types of documentation. If applicable, the landlord or owner needs to provide proof of residency from the following.

GROUP B:

- | | |
|---|--|
| <input type="checkbox"/> Tax Bill | <input type="checkbox"/> Insurance Policy and/or Bill |
| <input type="checkbox"/> Bank Statement | <input type="checkbox"/> IRS Tax Return |
| <input type="checkbox"/> Electric and Gas Bill | <input type="checkbox"/> Voter Registration Card |
| <input type="checkbox"/> Current Payroll Stub | <input type="checkbox"/> Moving Company Delivery Receipt |
| <input type="checkbox"/> Telephone Bill | <input type="checkbox"/> Official Postal Address Change |
| <input type="checkbox"/> Medicaid Forms | <input type="checkbox"/> Documents Issued by Federal, State or Local Agencies Form |
| <input type="checkbox"/> Cell Phone Bill | <input type="checkbox"/> Health Care Benefits Statement |
| <input type="checkbox"/> Driver's License or Non-Driver ID with Address | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cable Bill | |
| <input type="checkbox"/> Vehicle Registration | |

PROOF OF AGE (One of the following)

- Original or Certified Copy of your child's Birth Certificate regardless of issuing nation
- Original or Certified Copy of your child's Baptismal Certificate regardless of the issuing nation

If you are unable to provide either of the above documents:

- Your child's Passport regardless of the issuing nations

In the absence of the above documents, you may provide any other documentation that has been in existence for over two years that could be used to establish your child's age. For example:

- Official Driver's License or Non-Driver ID Card
- State or Local Government Issued Identification
- Military Dependent ID Card
- School Photo Identification with Date of Birth
- Consulate Identification Records
- Hospital or Health Records
- Documents Issued by Federal, State or Local Agencies
- Court Orders or Other Court Issued Documents
- Native American Tribal Document
- Records from Non-Profit International Aid Agencies and Voluntary Agencies

PROOF OF CUSTODY, GUARDIANSHIP OR FOSTER CARE

- If parents are separated, divorced or have a custody order, these documents must be provided to the District. If foster parents, documents from NYS Office of Children and Family Services (e.g., LDSS-2999)
- If custody/guardianship is with a third party, you must complete and submit Affidavits of Responsibility (Parent and Custodial Person). The District will consider requests for exceptions to this requirement in limited but appropriate circumstances.
- Government-issued Picture ID of the Parent/Guardian

CUSTODY PAPERS (If applicable) _____

HEALTH RECORDS _____

(Including Immunization Records and Physical Examination within 12 months of start of school year)

SCHOOL RECORD/REPORT CARD _____

(If a student is coming from another school district, you must ask if either of the documents below is applicable to this student.)

IEP (Spec Ed only) _____

In order to make a timely decision regarding a student’s right to enrollment or continued enrollment in the District, the above information and documentation should be delivered to the Registrar.

REGISTRAR: Put your initials on the line next to each document that you collect from the parent/legal guardian above. Once the packet is complete, attach this cover sheet to the packet and give to the building principal for verification.

PRINCIPAL: Building principal will initial “custody papers” above if applicable. The Director of Special Education will initial “IEP” if applicable. Only the building principal can sign the verification below once all paperwork has been received and reviewed.

Building Principal’s Signature

Date



**CHESTER UNION FREE SCHOOL DISTRICT
NEW STUDENT ENROLLMENT FORM**

www.chesterufsd.org

845-469-2231

___ Chester Academy

___ Chester Elementary School

Student Name: _____ Gender: Male
(last name) (first name) (middle name) Female
 Non-Binary

Date of Birth: _____ Place of Birth _____ Entry Grade _____
(mm/dd/yyyy) (City/Town, State)

Address: _____
Street Apt. City/Town State Zip

Previous School: _____

Please check if student _____ Any other special needs or considerations _____
 ___ Has an IEP (special education) _____
 ___ Has a 504 _____

Race (check all that apply): ___ White/Caucasian ___ Black or African American ___ Asian
 ___ American Indian/Alaskan Native ___ Native Hawaiian/Other Pacific Islander
 ___ Hispanic ___ Non-Hispanic

Dominant language spoken in home: 1st _____ 2nd _____

Language student is fluent in _____

Sibling Name(s)	Date of Birth	Grade	Gender

**CHESTER UNION FREE SCHOOL DISTRICT
SERVICE HISTORY FORM**

STUDENT NAME: _____ D.O.B.: _____

New Registrant Service History

Has your child attended Preschool? Yes No

If yes, Where? _____ How many years? _____

Has your child ever had any of the following services or evaluations?

1. Has your child received services through Early Intervention (EI)?

Yes No

2. Special Education Services:

Has your child ever been classified by a Committee on Preschool Special Education (CPSE)? Yes No

Does your child have an Individual Education Plan (I.E.P.)?

Yes No

3. Related Services through Early Intervention, CPSE or privately.

Yes No

Speech/language

Counseling

Occupational Therapy

Special Education Class

Physical Therapy

Vision

Hearing

Other: _____

4. Does your child have any special needs the school district should be aware of?

5. Are you and the student involved in a foster care relationship? Yes No

Signature _____ Date _____

Emergency Contact Form

Student Name: _____ Grade: _____

(last name)

(first name)

Parent/Guardian _____

Address _____

Student Resides With Yes No

Translation Preferred Yes No

Cell Phone Number _____

Work Phone Number _____

Email _____

Parent is a member of the Armed Forces and on Active Duty

Yes No

Parent/Guardian _____

Address _____

Student Resides With Yes No

Translation Preferred Yes No

Cell Phone Number _____

Work Phone Number _____

Email _____

Parent is a member of the Armed Forces and on Active Duty

Yes No

If my child has to be taken home because of a minor illness and I am not there or cannot be reached, please call:

Name of 1st Contact _____ Relationship _____

Phone Number _____ Phone Number _____ Address _____

Name of 2nd Contact _____ Relationship _____

Phone Number _____ Phone Number _____ Address _____

Name of 3rd Contact _____ Relationship _____

Phone Number _____ Phone Number _____ Address _____

Doctor _____ Address _____ Phone _____

My child has the following condition or allergy which requires special handling in any emergency _____

Are there any individuals whose access to your child is prohibited or restricted by court order? ____
If yes, please attach copies of court order

In an emergency, when you cannot reach one of the above, I authorize the school to call 911. This authorization also includes permission to release pertinent medical records needed. In the event that one of the parents/guardians cannot be reached, please take my child to the nearest emergency treatment facility, by ambulance if necessary. I realize the school district cannot assume responsibility for the payment of medical fees or expenses incurred.

Parent Signature _____ Date _____

CHESTER UNION FREE SCHOOL DISTRICT
RESIDENCY QUESTIONNAIRE

Name of LEA: **CHESTER UNION FREE SCHOOL DISTRICT**

Name of School: _____

Student Name: _____
(last name) (first name) (middle name)

Address: _____
Street, Apartment Unit # City/Town State Zip

Phone: _____ Date of Birth _____

Gender: _____ Male _____ Female _____ Non-Binary Grade _____ Student # (optional) _____

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, proof of age, school records, or immunization records. 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 _____
Parent, Guardian or Student (for accompanied homeless youth)

Signature _____
Parent, Guardian or Student (for accompanied homeless youth)

Date _____

If ANY box other than "In Permanent Housing" is checked, then the student/family should be immediately referred to the McKenney-Vento (MV) Liaison. In such cases, 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 MV liaison must help the student get any other necessary documents or immunizations.

Chester Union Free School District

64 HAMBLETONIAN AVENUE
CHESTER, NEW YORK 10918

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

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 style="text-align: right; font-size: small;">specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i style="text-align: right; font-size: small;">specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i style="text-align: right; font-size: small;">specify</i>	<input type="checkbox"/> Father _____ <i style="text-align: right; font-size: small;">specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i style="text-align: right; font-size: small;">specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i style="text-align: right; font-size: small;">specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i style="text-align: right; font-size: small;">specify</i>
		<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i style="text-align: right; font-size: small;">specify</i>
		<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English <input type="checkbox"/> Other	_____ <i style="text-align: right; font-size: small;">specify</i>
		<input type="checkbox"/> 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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING
 MO. DAY YR.

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:



CHESTER ELEMENTARY SCHOOL

2 Herbert Drive, Chester, NY 10918

(845) 469-2178

Principal: *Mary Kate Boesch*

marykate.boesch@chesterufsd.org

Immunization Requirement for Students

New York State Law Section 2164 requires certain immunizations (shots) to enter Pre-K or Kindergarten and attend school. Please check with your healthcare provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below.

	K - 5th Grade	Pre-K
Polio	4 doses	3 doses
Hepatitis B	3 doses	3 doses
Diphtheria/Tetanus/Pertussis	5 doses	4 doses
Measles/Mumps/Rubella	2 doses	1 dose
Varicella (chicken pox)	2 doses	1 dose
HIB	N/A	1-4 doses
Pneumococcal	N/A	1-4 doses
Lead Screening	N/A	Yes

Proof of immunization must be **any 1 of the 3** items listed below:

- An immunization certificate **signed & stamped** by your healthcare provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your healthcare provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases
- For varicella (chickenpox), a note from your healthcare provider which says your child had the disease is also acceptable.

Documentation must be provided prior to your child starting school.

If you have questions or concerns about immunizations, please contact the school health staff:

Nurse: Mrs. Denise Rydell
Phone: 845-469-2178 x2209

Email: ces.health@chesterufsd.org
Fax: 845-469-2170

CHESTER UNION FREE SCHOOL DISTRICT
HEALTH OFFICE

_____ **Chester Academy**
64 Hambletonian Avenue
Chester, New York 10918
Phone: 845-469-2231 x3315
FAX: 845-469-6634

_____ **Chester Elementary School**
2 Herbert Drive
Chester, New York 10918
Phone: 845-469-2178 x2209
FAX: 845-469-2170

Student Name: _____
(last name) (first name) (middle name)

Date of Birth _____ **Place of Birth** (City/Town, State) _____

Address: _____
Street, Apartment Unit # City/Town State Zip

Parent/Guardian _____ **Relationship** _____

Student Resides with YES NO **Cell Phone** _____ **Work Phone** _____

Parent/Guardian _____ **Relationship** _____

Student Resides with YES NO **Cell Phone** _____ **Work Phone** _____

Please indicate if your child has been treated for any of the following diseases/conditions:

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Earaches |
| <input type="checkbox"/> Chicken Pox Date: _____ | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bone Fracture(s) Seizures | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Frequent Sore Throats | |

Has your child been hospitalized for any serious illness or injury YES If Yes, please list _____

Does your child take medication regularly? YES Name of Medication _____

Does your child have any allergies? YES If Yes, please list _____

Has your child received medical treatment for any allergic reaction YES If Yes, please list _____

Does your child have any medical condition that could require immediate FIRST AID? YES
If yes, please describe: _____

Are there any special services that your child requires that the school should be made aware of? _____

Does your child wear glasses? YES NO Date of last eye exam: _____

PARENT/GUARDIAN SIGNATURE

DATE

CHESTER UNION FREE SCHOOL DISTRICT
HEALTH OFFICE

_____ **Chester Academy**

64 Hambletonian Avenue
Chester, New York 10918
Phone: 845-469-2231 x3315
FAX: 845-469-6634

_____ **Chester Elementary School**

2 Herbert Drive
Chester, New York 10918
Phone: 845-469-2178 x2209
FAX: 845-469-2170

Physical exams must be performed within the 12 months prior to the beginning of the school year in which the examination is required or within 15 days after registration in order to be acceptable. If you choose to have your child examined by your health care provider, please submit the completed medical form to the school health office by September 30th. If not received by this date, your child will be scheduled for a physical with the school nurse practitioner.

As part of a required school health examination, a student is weighed and his/her height is measured. These numbers are used to figure out the student's body mass index or 'BMI'. The BMI helps the doctor or nurse know if the student's weight is in a healthy range or is too high or too low. A sample of school districts will be selected to take part in a survey by the New York State Department of Health. If our school is selected to be part of the survey, we will be reporting to the New York State Department of Health information about our students' weight status groups. Only summary information is sent. No names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report. Please visit the district website to access the optional opt-out form.

Annual vision, hearing and scoliosis screenings will be performed according to the New York State guidelines.

If your child will need to take medication in school, please have your child's health care provider complete the Medication in School form which can be found on the Health Office Web page on the district website.

COMPLETE AND RETURN THIS SECTION:

- I will have my child examined by my own health care provider.
- The examination has been scheduled for the following date: _____
- I would like my child to be examined in school by the nurse practitioner.

STUDENT NAME _____ **GRADE** _____

PARENT/GUARDIAN SIGNATURE

DATE

Chester UFSD –SchoolTools Parent Portal Registration Form

All parents/guardians in the Chester Union Free School District are eligible to access the district’s Parent Portal through SchoolTools. This online service enables parents to view student information such as grades, report cards and emergency contact information. This will vary by school.

When your Parent Portal account is created by the school, you will receive a notification at the email address provided. The email will contain the link to SchoolTools Parent Portal and your password. Downloading the SchoolTool mobile app is encouraged.

Student Name _____ Grade _____

Student Name _____ Grade _____

Student Name _____ Grade _____

Student Name _____ Grade _____

Student Name _____ Grade _____

Name of parent/guardian requesting e-mail communication:

E-mail address: _____

Phone Number: _____

Name of parent/guardian requesting e-mail communication:

E-mail address: _____

Phone Number: _____

Parent/Guardian Signature: _____ **Date:** _____