

# Preschool Special Education Registration Requirements Students Ages 3-5

New York State requires all Preschool aged students **suspected of having a disability** to register within their home District. In order to refer your child to Preschool Special Education, you must first register with the school district.

Please note that Wallkill CSD does not have a district preschool program.

To register you need to supply us with the following:

- o Student Birth Certificate (Copy)  
Immunizations & Physical
- o Two (2) Proofs of Residency (Must have Street Address dated within the last 30 days, Post Office Boxes will not be accepted)
- o Custody Papers if applicable

Print and complete the forms attached below:

- Registration Form
- o Emergency Procedure Form/Preschool  
Physical Form | Return Original Copy
- o Home Language Survey
- o Request for Time in a Regular Early Childhood Program
- o Referral to CPSE with rationale

Return all documents to:

**Wallkill Central School District**  
PO Box 310 | 1500 Route 208  
**Wallkill, NY 12589**  
Attn: CPSE

Please call (845) 895-7114 with any questions or concerns you may have .

**If you are dropping off registration documents to the CPSE Department, the hours are 8:30-3:00 pm Monday through Friday.**

**\*\*IS YOUR CHILD CURRENTLY IN EARLY INTERVENTIONS YES \_\_\_ NO \_\_\_ COUNTY \_\_\_\_\_**

**Wallkill Central School District Student Registration  
Form 2025-2026**

*For Office Use Only*

Date \_\_\_/\_\_\_/\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_

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

**GENDER (check one)**  M  F

**SPECIAL EDUCATION SERVICES (check one)**  Yes  No (If Yes, Please Provide IEP)

**ETHNICITY (check one)**

- Hispanic/Latino  
 Not Hispanic/Latino

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

**RACE (check one)**

- American Indian or Alaskan Native  
 Asian  
 Native Hawaiian or Other Pacific Islander  
 Black or African American  
 White

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

Email \_\_\_\_\_

**FAMILY INFORMATION**

**Languages spoken at home** \_\_\_\_\_

**Student's language** \_\_\_\_\_

The student's ability to speak English is (Check one)  Fluent  Good  Fair  Not at all

**Student's place of birth** \_\_\_\_\_  
City State

**Custodial Papers (check one)**  Yes  No (If Yes, Please Provide)

**Does Student share households?**  Yes  No [If Yes, Provide Information on Emergency Card]

**Foster home placement (check one)**  Yes  No

**Agency Name/Address** \_\_\_\_\_ **Telephone Number** \_\_\_\_\_

**\*\*Is child living in any of the following situations (please check)**

- living in a shelter  living with relatives or others due to lack of housing  
 living in a motel/hotel/campground/car/bus/train station/due to lack of adequate housing  
 living in an alternative situation awaiting OCPS permanent foster care placement

2025 - 2026 WCSO Emergency Procedure Information  
PRESCHOOL

For Office Use Only  
Student ID#  
\_\_\_\_\_

\*\*\*IS YOUR CHILD CURRENTLY IN EARLY INTERVENTION? YES \_\_\_ NO \_\_\_ COUNTY \_\_\_\_\_

Student Date of Birth: \_\_\_/\_\_\_/\_\_\_

Student Name \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Relationship and name of persons) with whom student resides: \_\_\_\_\_

Name of Primary Household Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_ Cell Telephone # \_\_\_\_\_

Name of Secondary Household Parent/Guardian \_\_\_\_\_ Email \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_ Cell Telephone # \_\_\_\_\_

Siblings living in household:

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School \_\_\_\_\_ \ Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School \_\_\_\_\_ \ Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School \_\_\_\_\_ \ Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ School \_\_\_\_\_

\*\*Name, Address, Phone and Email of Parent NOT Residing with Student: \*\*

\*\*Name: \_\_\_\_\_ Email \_\_\_\_\_

\*\*Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_ Cell Telephone # \_\_\_\_\_

\*\*\*#2 Street Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

\*\*\*#2 Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Signature Primary Household Parent /Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature Secondary Household Parent /Guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



Liesette Colón-Collins, Assistant Commissioner  
Office of Bilingual Education and World Languages

55 Hanson Place, Room 504  
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:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> 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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____ specify	<input type="checkbox"/> Father _____ specify
	<input type="checkbox"/> Guardian(s)	_____ specify	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <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:

Wallkill CSD PO Box 310, Wallkill, NY

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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes - Type of services received: _____	
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____	

Signature of Parent or of Person in Parental Relation	Month:    Day:    Year:
Date	
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> 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: _____ <small>Mo.    DAY    YR.</small>	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: _____ <small>Mo.    DAY    YR.</small>	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:	

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  
**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent	<input type="checkbox"/> Other : _____

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

**Risk Factors for Diabetes or Pre-Diabetes:**

*Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.*

BMI \_\_\_\_\_ kg/m2 Percentile (Weight Status Category):  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

Hyperlipidemia:  No  Yes      Hypertension:  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_

TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g}/\text{dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

**Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities**

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:			DOB:										
<b>SCREENINGS</b>													
<b>Vision</b>	<b>Right</b>	<b>Left</b>	<b>Referral</b>	<b>Notes</b>									
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Distance Acuity With Lenses	20/	20/											
Vision – Near Vision	20/	20/											
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail													
<b>Hearing</b>	<b>Right dB</b>	<b>Left dB</b>	<b>Referral</b>										
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No										
<b>Scoliosis</b> Required for boys grade 9 And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Deviation Degree:		Trunk Rotation Angle:											
<b>Recommendations:</b>													
<b>RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK</b>													
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations      Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports              Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports          Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions:													
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V													
<input type="checkbox"/> Accommodations: Use additional space below to explain <table style="width:100%; border: none;"> <tr> <td style="border: none;"><input type="checkbox"/> Brace*/Orthotic</td> <td style="border: none;"><input type="checkbox"/> Colostomy Appliance*</td> <td style="border: none;"><input type="checkbox"/> Hearing Aids</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Insulin Pump/Insulin Sensor*</td> <td style="border: none;"><input type="checkbox"/> Medical/Prosthetic Device*</td> <td style="border: none;"><input type="checkbox"/> Pacemaker/Defibrillator*</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Protective Equipment</td> <td style="border: none;"><input type="checkbox"/> Sport Safety Goggles</td> <td style="border: none;"><input type="checkbox"/> Other:</td> </tr> </table> <p>*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.</p>					<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*	<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:
<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids											
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*											
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:											
Explain: _____													
<b>MEDICATIONS</b>													
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached													
List medications taken at home:													
<b>IMMUNIZATIONS</b>													
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No									
<b>HEALTH CARE PROVIDER</b>													
Medical Provider Signature:				Date:									
Provider Name: <i>(please print)</i>				Stamp:									
Provider Address:													
Phone:													
Fax:													
<b>Please Return This Form To Your Child's School When Entirely Completed.</b>													

# WCSD



Wallkill Central School District, 1500 Route 208, PO Box 310, Wallkill, New York 12589

(845) 895-7114, Fax: (845) 895-8079

## PRESCHOOL

DATE: \_\_\_\_\_

I, \_\_\_\_\_ parent of \_\_\_\_\_

would like to refer my child for an evaluation to determine if he/she is eligible for preschool special education services. The reasons for this referral are as follows (please be specific):

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\_\_\_\_\_  
Parent Signature

**WCSD**

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**PRESCHOOL**

Request for Time Enrolled in a Regular Early Childhood Program

Dear Parent,

As required by the New York State Education Department, all school districts must report the total time parents of preschool children have enrolled their child in any Regular Early Childhood Program. Examples of Regular Early Childhood Program could be private preschools, Head Start Centers, child care facilities or regular preschool classrooms open to pre-kindergarten population by the public school system.

To assist us in reporting this information to the New York State Education Department, please complete and return the enclosed form.

Thank you for your attention, and we appreciate your assistance in this matter. If you have any questions or concerns, please do not hesitate to call.

Sincerely,

*Tara Rounds*

*Assistant Superintendent for Special Education and Intervention Services*



Walkkill Central School District 19 Main Street, Box 310, Walkkill NY 12589

**PRESCHOOL**

**Request for Time Enrolled in a Regular Early Childhood Program**

My child does not attend a Regular Early Childhood Program.

My child does attend a Regular Early Childhood Program as indicated below:

The name of the Program(s) is/are: \_\_\_\_\_  
And my child typically attends the program(s) for the amount of time of each day indicated below:

Monday	Tuesday	Wednesday	Thursday	Friday	Total Hours for the Week

\_\_\_\_\_  
STUDENT'S NAME

\_\_\_\_\_  
STUDENT'S DATE OF BIRTH

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE