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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. - 3:00 p.m. during the school year and from 9:00 a.m. - 2:00 p.m. throughout the summer. Parents/Guardians should obtain and complete a registration packet prior to scheduling an appointment. Packets are available at the Registrar's office and on the school website at

www.kingstoncityschools.org/departments/registration

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 with your child's start date.**

Required Forms to Complete for Registration:

- 1. Housing Questionnaire**
- 2. Student Registration Form**
- 3. Home Language Questionnaire Form**
- 4. Request for Records Form- not applicable for kindergarten**
- 5. Health History Form/Immunization Record**
- 6. Medicaid Consent Form**

Questions or to Schedule an Appointment:

Call (845) 943-3011 or Email Registration@kingstoncityschools.org

Student Name _____ School/Grade _____

Parent/Guardian Name _____ Phone Number _____



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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/medial practice.

Custody/Guardian Papers

Necessary in the case of divorce, re-marriage or transfer of guardianship between family members.

Parent or Guardian Photo Identification: Drivers 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)
3. For Special Education Students: Most recent copy of IEP (Individualized Education Plan)

District Residency

One of the following residency proofs must be provided:

A. Owns home, or

- a. Most recent utility bill/tax or mortgage statement- must have name and property/residence address

B. Rents home, or

- a. Lease agreement, must have name and property/residence address
- b. Parent's name must appear on lease
- c. 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

- a. 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 provide a bill (electric, phone, water, oil) showing their name and property/residence address.

**** The following will NOT be accepting as proof of residency: Driver's License, Checkbook, Rent Receipt, Car Insurance Cards, and Bank Statements.**

**** CLASSIFIED STUDENT- YES or NO**

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the district shares with families. 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.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____

Last First Middle

Gender: Male
 Female
 Non-binary

Date of Birth: ____ / ____ / ____ Grade: ____ ID#: ____
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 **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the 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 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.



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KINGSTON CITY SCHOOL DISTRICT PUPIL REGISTRATION FORM

DATE: _____ GRADE: _____

Student Name: _____ Gender: _____ Hispanic [] YES [] NO

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) _____

Custody Papers or Guardian Warnings? [] NO [] YES

Explain: _____

PreK Experience: [] YES [] NO If yes, where? _____

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 last school 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

Phone 1 _____ Phone Type Cell Home Work; Contact Priority ____

Phone 2 _____ Phone Type Cell Home Work; Contact Priority ____

Email Address: _____

Employer's Name _____ Employer's Phone # _____ Priority ____

Employer's Address _____

Currently Serving Active Military Duty Yes No If Yes, date enlisted: _____ Date exited: _____

Parent/Guardian Name _____
(Last) (First) (Middle)

Relationship _____ Legal Custody? Yes No

Phone 1 _____ Phone Type Cell Home Work; Contact Priority ____

Phone 2 _____ Phone Type Cell Home Work; Contact Priority ____

Email Address: _____

Employer's Name _____ Employer's Phone # _____ Priority ____

Employer's Address _____

Currently Serving Active Military Duty Yes No If Yes, date enlisted: _____ Date exited: _____

INFORMATION TO BE COMPLETED FOR PARENTS/GUARDIANS *WHO DOES NOT LIVE IN THE SAME HOUSEHOLD AS THE CHILD(REN):*

Parent/Guardian Name _____
(Last) (First) (Middle)

Relationship _____ Legal Custody? Yes No

Phone 1 _____ Phone Type Cell Home Work; Contact Priority ____

Phone 2 _____ Phone Type Cell Home Work; Contact Priority ____

Email Address: _____

Employer's Name _____ Employer's Phone # _____ Priority ____

Employer's Address _____

Currently Serving Active Military Duty Yes No If Yes, date enlisted: _____ Date exited: _____

EMERGENCY CONTACT INFORMATION- OTHER THAN PARENT/GUARDIAN:

Name _____
(Last) (First) (Middle)

Resides in Same Household Yes No

If different household:

Address: _____ City _____ State _____ Zip _____

Phone 1 _____ Phone Type Cell Home Work

Phone 2 _____ Phone Type Cell Home Work

Relationship to Student _____

Name _____
(Last) (First) (Middle)

Resides in Same Household Yes No

If different household:

Address: _____ City _____ State _____ Zip _____

Phone 1 _____ Phone Type Cell Home Work

Phone 2 _____ Phone Type Cell Home Work

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

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.

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

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"/> Parent 1	_____ specify	<input type="checkbox"/> Parent 2 _____ specify
	<input type="checkbox"/> Guardian(s)	_____ specify	_____ 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:

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? _____

 Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
 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: _____ <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:	



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Kingston City School District HEALTH HISTORY for REGISTRATION & ATHLETES

Please complete in **blue or black ink**

Name:		DOB:	Age:	Gender:
School:		Grade:	Date:	
Parent/Guardian: (person completing this form)		Home Phone: _____		
		Cell Phone: _____		
Has your child ever:	YES	NO	If YES, please explain and include date:	
Had an ongoing medical condition/medical specialist	<input type="checkbox"/>	<input type="checkbox"/>		
Had allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> food <input type="checkbox"/> environmental <input type="checkbox"/> insect <input type="checkbox"/> medication <input type="checkbox"/> other	
Been hospitalized/had an operation	<input type="checkbox"/>	<input type="checkbox"/>		
Had an injury requiring an Emergency Room Visit	<input type="checkbox"/>	<input type="checkbox"/>		
Missed 5 days of school in a row due to illness/injury	<input type="checkbox"/>	<input type="checkbox"/>		
Had a bone/muscle injury	<input type="checkbox"/>	<input type="checkbox"/>		
Passed out, had a concussion or serious head injury	<input type="checkbox"/>	<input type="checkbox"/>		
Had a convulsion/seizure	<input type="checkbox"/>	<input type="checkbox"/>		
Had a vision problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> glasses <input type="checkbox"/> contacts	
Had a hearing problem or condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> hearing aid <input type="checkbox"/> cochlear implant	
Worn dental bridge, braces or mouth pieces	<input type="checkbox"/>	<input type="checkbox"/>		
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 heartbeat, 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:

<input type="checkbox"/> ADHD	<input type="checkbox"/> GI Conditions (ulcer, reflux, IBS)	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma/trouble breathing	<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Single Organ-
<input type="checkbox"/> Autism/Asperger	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Dental Injuries	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Speech Condition
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Health Condition	<input type="checkbox"/> Urinary Condition
<input type="checkbox"/> Ear Infections		

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			<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other
TREATMENTS	YES	NO	
DURING OR OUTSIDE OF SCHOOL			<input type="checkbox"/> Insulin/blood glucose monitoring <input type="checkbox"/> inhaler/nebulizer/peak flow monitoring <input type="checkbox"/> special diet

Is there any condition that would prevent your child from participating in physical education or sports?

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____



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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 code:		
School Phone Number:		
School Fax Number:		
Does your student have an IEP (Individualized Education Plan)	<input type="checkbox"/> YES <input type="checkbox"/> 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 Phone: (845) 943-3392 Fax: (845) 336-5616	_____ Edward R. Crosby Elementary School 767 Neighborhood Road Lake Katrine, NY 12449 Phone: (845) 943-3333 Fax: (845) 382-2668	
_____ Harry L. Edson Elementary School 116 Merilina Avenue Kingston, NY 12401 Phone: (845) 943-3913 Fax: (845) 331-9034	_____ Robert Graves Elementary School 345 Mountain View Ave. (PO BOX 549) Port Ewen, NY 12466 Phone: (845) 943-3422 Fax: (845) 338-3049	
_____ John F. Kennedy Elementary School 107 Gross Street Kingston, NY 12401 Phone: (845) 943-3100 Fax: (845) 331-2477	_____ Ernest C. Myer Elementary School 121 Schoolhouse Road Hurley, NY 12443 Phone: (845) 943-3484 Fax: (845) 331-1520	
_____ George Washington Elementary School 67 Wall Street Kingston, NY 12401 Phone: (845) 943-3513 Fax: (845) 338-3041	_____ M. Clifford Miller Middle School 65 Fording Place Road Lake Katrine, NY 12449 Phone: (845) 943-3638 (Guidance) Fax: (845) 382-6069	
_____ J. Watson Bailey Middle School 118 Merilina Avenue Extension Kingston, NY 12401 Phone: (845) 943-3572 (Guidance) Fax: (845) 943-3240	_____ Kingston High School 403 Broadway Kingston, NY 12401 Phone: (845) 943-3970 Fax: (845) Guidance Counselor: _____	

For students with IEP's, send duplicate copy of records and IEP with all evaluations to:

KCSD Special Education Department
21 Wynkoop Place
Kingston, NY 12401
Phone: (845) 943-3073; Fax: (845) 943-3213



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AFFIDAVIT OF PROPERTY OWNER/LANDLORD
IN SUPPORT OF RESIDENCY IN THE KINGSTON CITY SCHOOL DISTRICT

I _____ a property owner or manager/agency of the dwelling located at
_____.
(Street Address/Apt #) (City, State, Zip)

Herby certify that I am renting space in the dwelling on a _____ basis beginning on _____.
(Weekly/Monthly/Yearly) (Date)

The following person(s) are identified as tenants having the right to occupy in the dwelling:

- Parent/Guardian: _____
• Parent/Guardian: _____
• 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.

Sworn to before me on this

_____.
Signature of Property Owner/Landlord or Property Manager

_____ day of _____ 20_____

_____.
Print Name

_____.
Notary Public
State of:
County of:



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Kingston City School District
Committee of Special Education
21 Wynkoop Place
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 plan (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 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 Student's Services or Program
Evaluation Reports	Special Transportation Log	

Student's CIN, if known: _____

_____ I do not give consent to bill Medicaid Insurance Program for special education and related services that are on my child's individualized education plan (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: _____

Date: _____

Print Name: _____



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Statute: Section 4402

Effective Date: July 1, 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) website, provided that the district includes the name and contact information of the district's Committee of 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.

NYSED's A Parent's Guide to Special Education:

www.nysed.gov/special-education/parents-guide-special-education

KCSD Special Education Information:

www.kingstoncityschools.org/departments/special-education

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:

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.