



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

Welcome to the Kingston City School District!

This packet will need to be completed in full to be registered with the Kingston City School District.

Please check a box below to let us know what this application is for:

- Universal Preschool Application
- Preschool Special Education Evaluation Referral
- Both- UPK Application and Preschool Age Special Education Evaluation Referral

Thank you

Registration will contact you once the application is received.

Student Name \_\_\_\_\_ School/Grade \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone Number \_\_\_\_\_



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

## 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:** Drivers License, Passport, State ID
- Physical Exam dated within one year:** Must be completed by a NYS Licensed physician, physician assistant or nurse practitioner on the NYSED Student Health Examination Form (included in this packet)
- 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.
    - b.

**\*\* 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**



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

Completed Application \_\_\_\_\_

(for office use only)

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

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M  F

PARENTS/GUARDIANS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT): \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PHONE: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (mobile) \_\_\_\_\_

Have you had a child previously attend Pre-K?  YES  NO If yes, name of Agency \_\_\_\_\_

Do you feel your child has any special needs? If so, please explain: \_\_\_\_\_

**PLEASE CHECK PREFERRED UPK SITE: PLEASE PICK A 1<sup>ST</sup>, 2<sup>ND</sup>, AND 3<sup>RD</sup> CHOICE**

**FULL DAY 4-YEAR-OLD UPK (5 HOURS)**

- Meagher Preschool Center- 21**  
Wynkoop Pl., Kingston (845) 943-3916
- Aunt Jenn's Early Learning Center-**  
925 Orlando St. Kingston, (845) 383-1060
- Little Red Schoolhouse – 637 Lucas**  
Ave. Extension, Hurley (845) 340-8460
- Lil' Learners Preschool (CCE)- 16**  
Cedar St. Kingston (845) 338-7664
- Kingston Catholic- 159 Broadway,**  
Kingston (845) 331-9318
- Montessori School of Kingston- 243**  
Hurley Ave., Kingston (845) 331-3311
- George Washington Elementary- 67**  
Wall St. Kingston (845) 943-3513

**HALF-DAY 4-YEAR-OLD UPK (2 ½ HOURS)**

- Hurley Nursey School- Main St.**  
Hurley (845) 339-1036

*Universal Pre-Kindergarten program is a program which provides curriculum and activities, 5 days/week, Full-day (5 hrs) or Half-Day (2.5 hours), which are appropriate to the age-level and individual needs of eligible children, and which promote cognitive, linguistic, physical, cultural, emotional, and social development. Activities shall be learner-centered and shall be designed and provided in a way that promotes the child's total growth and development in all areas including emergent English literacy. Children are encouraged to be self-assured and independent.*

*Eligible children are those who reside within the school district and are FOUR years of age on or before December 1st of the year in which he or she is enrolled. Selection is based on a lottery system.*

**Transportation is NOT provided and is the responsibility of the parent/caregiver.**

\*After you have completed the entire application and compiled all supporting documents, email all documents to [jbarber@kingstoncityschools.org](mailto:jbarber@kingstoncityschools.org) or call the Registration Office to schedule an appointment. \*

Kingston City School District

ATTN: Jill Barber, Registration Office, 21 Wynkoop Place, Kingston, NY 12401  
P: 845-943-3011 E: [jbarber@kingstoncityschools.org](mailto:jbarber@kingstoncityschools.org)

## Kingston City School District UPK Sites

Site Name	Address and Phone Number	Number of UPK Classrooms	UPK Hours Monday-Friday	Wraparound Care Hours (*additional fee)
<b>Meagher Preschool (KCS D)</b>	21 Wynkoop Place Kingston, NY 12401 (845) 943-3451	6	8:20-2:00	AM: 7:00-8:20 PM: 2:00-6:00 <b>Call 338-3810 ext. 122</b>
<b>Aunt Jenn's Early Learning Center</b>	925 Orlando Street Kingston, NY 12401 (845) 383-1060	1	9:00-2:00	AM: 7:30-9:00 PM: 2:00-5:30
<b>Little Red Schoolhouse</b>	637 Lucas Ave. Ext. Hurley, NY 12443 (845) 340-8460	2	9:00-2:00	AM: 7:30-9:00 PM: 2:00-5:15
<b>Montessori of Kingston</b>	243 Hurley Ave. Kingston, NY 21401 (845) 331-3311	1	9:00-2:00	AM: 7:30-9:00 PM: 2:00-5:30
<b>George Washington (KSCD)</b>	67 Wall Street Kingston, NY 12401 (845) 943-3513	2	9:00-2:00	N/A
<b>Lil' Learners Preschool (Center for Creative Education) Mixed Aged Classroom (3 and 4 year olds)</b>	16 Cedar Street Kingston, NY 12401 (845) 338-7664	1	9:00-2:00	AM: 7:00-9:00 PM: 2:00-6:00
<b>Kingston Catholic</b>	159 Broadway Kingston, NY 12401 (845) 331-9318	1	7:45-12:45	Wraparound 12:45-2:45 Extended Day 2:45-5:30
<b>Hurley Nursery</b>	13 Main Street Hurley, NY 12443 (845) 339-1036	1	12:30-3:00	N/A

**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.



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

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): \_\_\_\_\_



**NEW YORK STATE EDUCATION DEPARTMENT  
Emergent Multilingual Learners Language Profile for  
Prekindergarten Students<sup>1</sup>**

*Dear Parent or Guardian,  
Thank you for completing the Emergent  
Multilingual Learners Language Profile.  
This survey will assist your new school  
with valuable information about your  
child's experience with languages.  
Information gathered will assist  
Prekindergarten educators in delivering  
academically and linguistically relevant  
instruction that strengthens the  
language and literacy of all students.*

<b>THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE</b>
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

***Parent or Person in Parental Relation Information***

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile:  mother  father  other \_\_\_\_\_

In what language(s) would you like to receive information from the school?  English  other home language:

***Language in the Home***

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home?  yes  no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings?  yes  no

If yes, in what language(s) do the children speak with each other most of the time? \_\_\_\_\_

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

***Language Outside the Home/Family***

10. Has your child attended any nursery, Head Start or childcare program?  yes  no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

***Language Goals***

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual?  yes  no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?

yes  no

If yes, in what language(s)?

***Emergent Literacy***

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English?  yes  no

16b. Can your child recognize letters or symbols in another language?  yes  no

If yes, in what language(s)?

17a. Does your child pretend to read?  yes  no  unsure

If yes, in what language(s)?

17b. Does your child pretend to write?  yes  no  unsure

If yes, in what language(s)?

18. Does your child tell the stories from his/her favorite books or videos?  yes  no

If yes, in what language(s)?

19. Does your child's childcare or nursery program describe goals for his or her learning?  yes  no

If so, what goals do they describe?

20. Please describe anything special you did to prepare your child to begin Prekindergarten.

---

<sup>1</sup> For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email [OEL@nysed.gov](mailto:OEL@nysed.gov) or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email [OBEWL@nysed.gov](mailto:OBEWL@nysed.gov).



# 48 Month Questionnaire

42 months 0 days through 53 months 30 days



Date ASQ:SE-2 completed: \_\_\_\_\_

## Child's information

Child's first name: \_\_\_\_\_ Child's middle initial: \_\_\_\_\_ Child's last name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Child's gender:  Male  Female

## Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State/province: \_\_\_\_\_ ZIP/postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Relationship to child:  Parent  Guardian  Teacher  Other: \_\_\_\_\_  
 Grandparent/other relative  Foster parent  Child care provider

People assisting in questionnaire completion: \_\_\_\_\_

## Program information

(For program use only.)

Child's ID #: \_\_\_\_\_ Age at administration in months and days: \_\_\_\_\_

Program ID #: \_\_\_\_\_

Program name: \_\_\_\_\_

# 48 Month Questionnaire 42 months 0 days through 53 months 30 days



Questions about behaviors children may have are listed on the following pages. Please read each question carefully and check the box  that best describes your child's behavior. Also, check the circle  if the behavior is a concern.

### Important Points to Remember:

- Answer questions based on what you know about your child's behavior.
- Answer questions based on your child's *usual* behavior, not behavior when your child is sick, very tired, or hungry.
- Caregivers who know the child well and spend more than 15-20 hours per week with the child should complete ASQ:SE-2.
- Please return this questionnaire by: \_\_\_\_\_
- If you have any questions or concerns about your child or about this questionnaire, contact: \_\_\_\_\_
- Thank you and please look forward to filling out another ASQ:SE-2 in \_\_\_\_\_ months.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
1. Does your child look at you when you talk to him?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
2. Does your child cling to you more than you expect?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
3. Does your child talk or play with adults she knows well?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
4. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
5. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
6. Does your child seem too friendly with strangers?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
7. Does your child settle himself down after exciting activities?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
8. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____



TOTAL POINTS ON PAGE \_\_\_\_\_

# 48 Month Questionnaire



Check the box  that best describes your child's behavior. Also, check the circle  if the behavior is a concern.

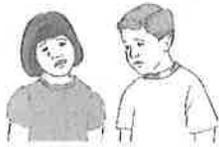
	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
9. Is your child interested in things around her, such as people, toys, and foods? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
10. Does your child stay dry during the day?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
11. Does your child have eating problems? For example, does he stuff food, vomit, eat things that are not food, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
12. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
13. Does your child do what you ask her to do?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
14. Does your child seem happy?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
15. Does your child sleep at least 8 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
16. Does your child seem more active than other children his age?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
17. Does your child use words to tell you what she wants or needs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
18. Does your child stay with activities he enjoys for at least 10 minutes (other than watching shows or videos, or playing with electronics)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
19. Does your child use words to describe her feelings and the feelings of others? For example, does she say, "I'm happy," "I don't like that," or "She's sad?"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 48 Month Questionnaire



Check the box  that best describes your child's behavior. Also, check the circle  if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
20. Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
21. Does your child explore new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
22. Does your child do things over and over and get upset when you try to stop him? For example, does he rock, flap his hands, spin, or _____? (Please describe.) _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
24. Does your child follow rules at home or at child care?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
25. Does your child destroy or damage things on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
26. Does your child stay away from dangerous things, such as fire and moving cars?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
27. Can your child name a friend?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
28. Does your child show concern for other people's feelings? For example, does he look sad when someone is hurt?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
					
29. Do other children like to play with your child?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

# 48 Month Questionnaire



Check the box  that best describes your child's behavior. Also, check the circle  if the behavior is a concern.

	OFTEN OR ALWAYS	SOME-TIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN	
30. Does your child like to play with other children? 	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
31. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
32. Does your child show an unusual interest in or knowledge of sexual language and activity?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
33. Does your child wake three or more times during the night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
34. Is your child too worried or fearful? If "sometimes" or "often or always," please describe: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____
35. Does your child have simple back-and-forth conversations with you? For example, Parent: "It's raining!" Child: "And cold outside." Parent: "Let's get your coat." Child: "I got it!"	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/> v	_____
36. Has anyone shared concerns about your child's behaviors? If "sometimes" or "often or always," please explain: _____ _____ _____	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/> v	_____

TOTAL POINTS ON PAGE \_\_\_\_\_

**OVERALL** Use the space below for additional comments.

37. Do you have concerns about your child's eating, sleeping, or toileting habits?  
If yes, please explain:

YES  NO

---

---

---

38. Does anything about your child worry you? If yes, please explain:

YES  NO

---

---

---

39. What do you enjoy about your child?

---

---

---

Child's name: \_\_\_\_\_ Date ASQ:SE-2 completed: \_\_\_\_\_

Child's ID #: \_\_\_\_\_ Child's date of birth: \_\_\_\_\_

Person who completed ASQ:SE-2: \_\_\_\_\_ Child's age in months and days: \_\_\_\_\_

Administering program/provider: \_\_\_\_\_ Child's gender:  Male  Female

### 1. ASQ:SE-2 SCORING CHART:

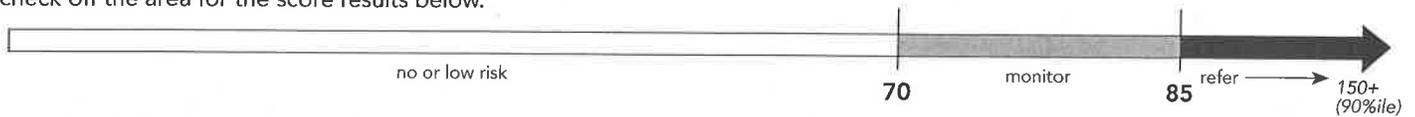
- Score items (Z = 0, V = 5, X = 10, Concern = 5).
- Transfer the page totals and add them for the total score.
- Record the child's total score next to the cutoff.

TOTAL POINTS ON PAGE 1	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
<b>Total score</b>	

Cutoff	Total score
85	

### 2. ASQ:SE-2 SCORE INTERPRETATION:

Review the approximate location of the child's total score on the scoring graphic. Then, check off the area for the score results below.



- \_\_\_ The child's total score is in the  area. It is below the cutoff. Social-emotional development appears to be on schedule.
- \_\_\_ The child's total score is in the  area. It is close to the cutoff. Review behaviors of concern and monitor.
- \_\_\_ The child's total score is in the  area. It is above the cutoff. Further assessment with a professional may be needed.

### 3. OVERALL RESPONSES AND CONCERNS:

Record responses and transfer parent/caregiver comments. YES responses require follow-up.

- 1-36. Any Concerns marked on scored items?    **YES**    no    Comments: \_\_\_\_\_
37. Eating/sleeping/toileting concerns?    **YES**    no    Comments: \_\_\_\_\_
38. Other worries?    **YES**    no    Comments: \_\_\_\_\_

### 4. FOLLOW-UP REFERRAL CONSIDERATIONS:

Mark all as Yes, No, or Unsure (Y, N, U). See pages 98-103 in the ASQ:SE-2 User's Guide.

- \_\_\_ **Setting/time factors** (e.g., Is the child's behavior the same at home as at school?)
- \_\_\_ **Developmental factors** (e.g., Is the child's behavior related to a developmental stage or delay?)
- \_\_\_ **Health factors** (e.g., Is the child's behavior related to health or biological factors?)
- \_\_\_ **Family/cultural factors** (e.g., Is the child's behavior acceptable given the child's cultural or family context? Have there been any stressful events in the child's life recently?)
- \_\_\_ **Parent concerns** (e.g., Did the parent/caregiver express any concerns about the child's behavior?)

### 5. FOLLOW-UP ACTION:

Check all that apply.

- \_\_\_ Provide activities and rescreen in \_\_\_ months.
- \_\_\_ Share results with primary health care provider.
- \_\_\_ Provide parent education materials.
- \_\_\_ Provide information about available parenting classes or support groups.
- \_\_\_ Have another caregiver complete ASQ:SE-2. List caregiver here (e.g., grandparent, teacher): \_\_\_\_\_
- \_\_\_ Administer developmental screening (e.g., ASQ-3).
- \_\_\_ Refer to early intervention/early childhood special education.
- \_\_\_ Refer for social-emotional, behavioral, or mental health evaluation.
- \_\_\_ Other: \_\_\_\_\_



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

## Kingston City School District HEALTH HISTORY for REGISTRATION & ATHLETES

Please complete in blue or black ink

<b>Name:</b>		<b>DOB:</b>	<b>Age:</b>	<b>Gender:</b>
<b>School:</b>		<b>Grade:</b>	<b>Date:</b>	
<b>Parent/Guardian: (person completing this form)</b>		<b>Home Phone:</b> _____		
		<b>Cell Phone:</b> _____		
<b>Has your child ever:</b>	<b>YES</b>	<b>NO</b>	<b>If YES, please explain and include date:</b>	
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"/>		
<b>Cardiac History:</b>	<b>YES</b>	<b>NO</b>	<b>If YES, please specify:</b>	
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		

<b>CURRENT MEDICATIONS</b>	<b>YES</b>	<b>NO</b>	<b>PLEASE LIST NAME, DOSE, TIME(S)</b>
GIVEN AT SCHOOL			
TAKEN AT HOME			
<b>ASSISTIVE EQUIPMENT</b>	<b>YES</b>	<b>NO</b>	<b>PLEASE CHECK ALL THAT APPLY</b>
DURING OR OUTSIDE OF SCHOOL			<input type="checkbox"/> crutches <input type="checkbox"/> walker <input type="checkbox"/> wheelchair <input type="checkbox"/> other
<b>TREATMENTS</b>	<b>YES</b>	<b>NO</b>	
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: \_\_\_\_\_

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

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM  
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR  
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

**HEALTH HISTORY**

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

**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/m<sup>2</sup>

**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:**  Yes  Not Done

**Hypertension:**  Yes  Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

<b>Height:</b>	<b>Weight:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Respirations:</b>
<b>Laboratory Testing</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Lead Level Required for PreK &amp; K</b>
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<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/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

Assessment/Abnormalities Noted/Recommendations: \_\_\_\_\_ Diagnoses/Problems (list) \_\_\_\_\_ ICD-10 Code\* \_\_\_\_\_

Additional Information Attached

\*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:
-------	--------------------------------	------

**SCREENINGS**

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>

Notes

<b>Hearing</b> Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.	<b>Not Done</b>
---	-----------------

Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes	<input type="checkbox"/>
---------------------	---	--	---------------------------------------	--------------------------

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>

**FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS\*/PLAYGROUND/WORK**

\*Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act

Student may participate in all activities without restrictions.

**If Restrictions Apply** – Complete the information below

Student is restricted from participation in:

- Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- Other Restrictions:**

**Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage:**  I  II  III  IV  V

**Other Accommodations\*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

\*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

**MEDICATIONS**

Order Form for medication(s) needed at school attached

**COMMUNICABLE DISEASE**

Confirmed free of communicable disease during exam

**IMMUNIZATIONS**

Record Attached  Reported in NYSIIS

**HEALTHCARE PROVIDER**

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please Return This Form to Your Child's School Health Office When Completed.**



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

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:



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

**Statue: 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](http://www.nysed.gov/special-education/parents-guide-special-education)

**KCSD Special Education Information:**

[www.kingstoncityschools.org/departments/special-education](http://www.kingstoncityschools.org/departments/special-education)

**Statue: 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.