



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 _____



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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/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**



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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 1ST, 2ND, AND 3RD 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 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

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)
Meagher Preschool (KCS D)	21 Wynkoop Place Kingston, NY 12401 (845) 943-3451	6	8:20-2:00	AM: 7:00-8:20 PM: 2:00-6:00 Call 338-3810 ext. 122
Aunt Jenn's Early Learning Center	925 Orlando Street Kingston, NY 12401 (845) 383-1060	1	9:00-2:00	AM: 7:30-9:00 PM: 2:00-5:30
Little Red Schoolhouse	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
Montessori of Kingston	243 Hurley Ave. Kingston, NY 21401 (845) 331-3311	1	9:00-2:00	AM: 7:30-9:00 PM: 2:00-5:30
George Washington (KSCD)	67 Wall Street Kingston, NY 12401 (845) 943-3513	2	9:00-2:00	N/A
Lil' Learners Preschool (Center for Creative Education) Mixed Aged Classroom (3 and 4 year olds)	16 Cedar Street Kingston, NY 12401 (845) 338-7664	1	9:00-2:00	AM: 7:00-9:00 PM: 2:00-6:00
Kingston Catholic	159 Broadway Kingston, NY 12401 (845) 331-9318	1	7:45-12:45	Wraparound 12:45-2:45 Extended Day 2:45-5:30
Hurley Nursery	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.



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KINGSTON CITY SCHOOL DISTRICT PUPIL REGISTRATION FORM

DATE: GRADE: Gender:

Student Name: 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 _____

Address _____ City _____ State _____ Zip _____

Mailing Address, if different _____

(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 Students¹**

*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.*

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
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? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure If yes, in what language(s)?
17b. Does your child pretend to write? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unsure If yes, in what language(s)?
18. Does your child tell the stories from his/her favorite books or videos? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, in what language(s)?
19. Does your child's childcare or nursery program describe goals for his or her learning? <input type="checkbox"/> yes <input type="checkbox"/> no If so, what goals do they describe?
20. Please describe anything special you did to prepare your child to begin Prekindergarten.

¹ For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email 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.



48 Month Questionnaire

42 months 0 days through 53 months 30 days

ASQ:SE-2

Ages & Stages
Questionnaires®

Social-Emotional

SECOND EDITION

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 <i>other</i> 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:

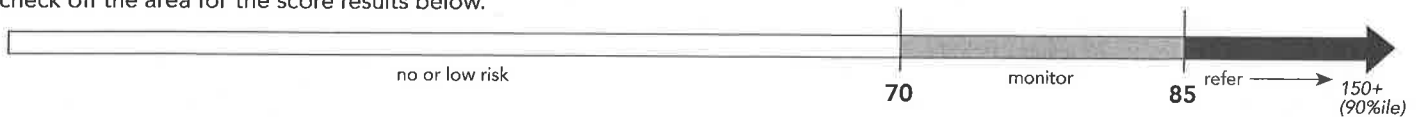
- Score items (Z = 0, V = 5, X = 10, Concern = 5).
- Transfer the page totals and add them for the total score.
- Record the child's total score next to the cutoff.

TOTAL POINTS ON PAGE 1	
TOTAL POINTS ON PAGE 2	
TOTAL POINTS ON PAGE 3	
TOTAL POINTS ON PAGE 4	
Total score	

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: _____



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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: _____

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/m²

Percentile (Weight Status Category): < 5th 5th- 49th 50th- 84th 85th- 94th 95th- 98th 99th and >

Hyperlipidemia: Yes Not Done

Hypertension: Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 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:
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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

Hearing 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.	Not Done
---	-----------------

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.



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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: _____
• Student Name: _____ Grade: _____
• Student Name: _____ Grade: _____
• Student Name: _____ Grade: _____
• Student Name: _____ Grade: _____

The payment of Electric Utility Bill is included in rent: Yes: _____ No: _____

I certify that the information provided on this form is true and correct and that the statements made herein are being made
under the penalties of perjury, knowing that the Kingston City School District will rely upon them in determining whether the
above-named child(ren) reside in the school district.

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:

**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: _____

Consentimiento de Medicaid

RE:

Fecha de nacimiento (DOB):

Número de Identificación del Cliente (CIN):

Esto es para pedir su permiso (consentimiento) para facturar a su Programa de Seguro de Medicaid o al de su hijo/a por los servicios de educación especial y servicios relacionados que están en el Plan Educativo Individualizado (IEP) de su hijo/a, y para pedirle que nos proporcione el Número de Identificación del Cliente (CIN) de su hijo/a o nos permita obtenerlo si usted no lo sabe.

Este consentimiento permite que el distrito escolar/condado facture a Medicaid por los servicios de salud cubiertos y que divulgue información al Agente de Facturación de Medicaid del distrito escolar/condado para ese propósito.

Yo, _____ como padre/madre/tutor de _____, he recibido una notificación por escrito del distrito escolar/condado que explica mis derechos federales con respecto al uso de beneficios públicos o seguros para pagar ciertos servicios de educación especial y servicios relacionados.

Entiendo y acepto que el distrito escolar/condado puede solicitar un Número de Identificación del Cliente (CIN), verificar la elegibilidad de Medicaid y/o acceder a Medicaid para pagar los servicios de educación especial y servicios relacionados proporcionados a mi hijo/a.

Entiendo que:

- Dar consentimiento no afectará la cobertura de Medicaid de mi hijo/a o la mía.
- A solicitud, puedo revisar copias de los registros divulgados conforme a esta autorización.
- Los servicios enumerados en el IEP de mi hijo/a deben proporcionarse sin costo para mí, ya sea que dé o no consentimiento para facturar a Medicaid y/o proporcionar el CIN de mi hijo/a.
- Tengo derecho a retirar el consentimiento en cualquier momento
- El distrito escolar/condado debe darme una notificación anual por escrito sobre mis derechos con respecto a este consentimiento.

_____ **Doy mi consentimiento** voluntariamente y entiendo que puedo retirarlo en cualquier momento. También entiendo que el derecho de mi hijo/a a recibir servicios de educación especial y relacionados no depende de que yo otorgue este consentimiento y que, independientemente de mi decisión, todos los servicios requeridos en el IEP de mi hijo/a se proporcionarán sin costo para mí. También doy mi consentimiento para que el distrito escolar/condado divulgue los siguientes registros/información sobre mi hijo/a a la Agencia Estatal de Medicaid con el propósito de verificar la elegibilidad de Medicaid y/o facturar por los servicios de educación especial y relacionados que están en el IEP de mi hijo/a. Los siguientes registros se compartirán:

Registros a compartir (por ejemplo, registros o información sobre los servicios que recibe su hijo, información demográfica del estudiante):		
IEP	Notas de sesión	Otra información personal identificable
Orden/Referencia por escrito	Informe de administración de medicamentos	Cualquier otro registro específico relacionado con los servicios o el programa del estudiante
Informes de evaluación	Registro de transporte especial	

CIN del estudiante, si se conoce: _____

_____ **No doy mi consentimiento** para facturar al Programa de Seguro de Medicaid por los servicios de educación especial y relacionados que están en el IEP de mi hijo/a. Independientemente de mi decisión de negar el consentimiento, todos los servicios requeridos en el IEP de mi hijo/a se proporcionarán sin costo para mí.

Firma del padre/madre/tutor: _____

Fecha: _____

Nombre en letra de imprenta: _____



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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

KCSD Special Education Information:

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.