



(845) 895-7100, Fax: (845) 895-3630

Anthony White
Superintendent of Schools

Brian Masopust
Assistant Superintendent for Educational Services

Tara Rounds
**Asst. Superintendent for Special Education
& Intervention Services**

Brian Devincenzi
Assistant Superintendent for Support Services

CENTRAL REGISTRATION

Dear Parent/Guardian,

The Wallkill Central School District registers all students at the District Office located at 1500 Route 208, Wallkill, New York 12589. To register your child or children, please bring the following items with you, as we cannot process your registration without these documents. Your child(ren) will be permitted to begin attending school as soon as practicable, pending a final determination of the child(ren)'s residency. Please be advised that your building principal will be contacting you about student placement, since class sizes may reach maximum numbers and your child may have to attend another elementary school outside your attendance area.

Student Information

- Pupil Birth Certificates or other satisfactory evidence of age shall be presented at the initial registration - Pre-Kindergarten (Student Must Be 4 Years of Age by December 1st) and Kindergarten (Student Must Be 5 Years of Age by December 1st)
- Immunization Records (**School will need most recent Physical as well**)
- Report Card from Previous School [include name, address, and telephone number of school] (if available) ☐ Custodial Papers or Affidavits (if appropriate and available)
- IEP (if appropriate)
- Completed documents attached below (Confidential Health Card, Emergency Contact Numbers, Home Language Questionnaire, Media Release, Student Information Form and Release of Information Form).

Proof of Residence in District

Must present two (2) [must have street address, **no PO Box**]

Examples of proof include, but are not limited to:

- Mortgage or deed
- Rental/Lease Agreement
- Utility Bill [Central Hudson, Telephone, Cable, etc.]
- Driver's License, learner's permit or non-driver identification
- State or other government issued identification
- Pay Stub with address
- Voter Registration Card
- Post Office Form with forwarding address (Complete On-Line at USPS.com)
- Social Services check or unemployment check with new address
- Income tax form
- Notarized or signed statement from a third party landlord, owner or tenant with whom you are sharing property
- Notarized or signed statement from a third party establishing your physical presence in the district
- Membership documents (e.g. library card) based upon residency
- Documents issues by federal, state or local agencies (e.g. federal Office of Refugee Resettlement)

Parent Identification

- State Issued Driver's License or State Issued Picture ID (one or both parents, if available)

This document and a Physical Examination form may be downloaded by clicking the appropriate links below. If you have any questions regarding registration, please call (845) 895-7105. Thank you.

Updated: May 2023

2026-2027 EMERGENCY CALLING SYSTEM CONTACT NUMBERS

STUDENT NAME _____

STUDENT ID# (Preschool Children) _____

SCHOOL _____

GRADE _____

PARENT/GUARDIAN NAME _____

DO NOT USE PHONES THAT REQUIRE EXTENSION NUMBERS

EMERGENCY PHONE NUMBER 1: _____

EMERGENCY PHONE NUMBER 2: _____

PARENT/GUARDIAN **EMAIL** 1: _____ *Mother I Father*
****Please print clearly**** *(Circle One)*

PARENT/GUARDIAN **EMAIL** 2: _____ *Mother I Father*
****Please print clearly**** *(Circle One)*

***** PLEASE COMPLETE AND RETURN TO THE MAIN OFFICE *****

2026-2027 CONFIDENTIAL
Grades K-12

For Office Use Only
Student ID# _____

Wallkill Central School District Emergency & Health Information
[Health information will be shared with personnel on a need to know basis]

Student Name _____ Home Telephone # _____
Last First

Grade _____ Date of Birth ____/____/____ Student ID# Teacher/Homeroom Bus #

Primary Parent Name/Work Tel #: _____ W# _____ Cell #: _____

Secondary Parent Name/Work Tel #: _____ W# _____ Cell #: _____

Emergency Contact #1: Name: _____ Telephone #: _____

Emergency Contact #2: Name: _____ Telephone #: _____

Emergency Contact #3: Name: _____ Telephone #: _____

Please list health condition(s) that may require special care.

Allergies _____

Medication Taken at Home _____

Medication Taken at School _____

*Has your child *during the past year* had an illness, injury, operation(s) or required special medical care?

*Has the student had any immunizations or communicable disease *during the past year only?*
(Please provide Physician's verification of the immunization.)

Family Physician _____ Telephone #: _____

Family Dentist _____ Telephone #: _____

Hospital (in event of serious injury) _____

*I authorize the Wallkill Central School District to act as temporary guardian to obtain medical or surgical
care necessary for my child (name) _____ *IF I CANNOT BE CONTACTED*

Primary Parent/Guardian Signature _____ Date _____

Secondary Parent/Guardian Signature _____ Date _____

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

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

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental	☐ Anaphylaxis Care Plan Attached ☐ Asthma Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Intermittent ☐ Persistent ☐ Other : _____	☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Type: _____	☐ Seizure Care Plan Attached Date of last seizure: _____
Diabetes ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____	☐ 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): ☐ <5 th ☐ 5 th -49 th ☐ 50 th -84 th ☐ 85 th -94 th ☐ 95 th -98 th ☐ 99 th and >		
Hyperlipidemia: ☐ No ☐ Yes Hypertension: ☐ No ☐ Yes		

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	☐ Mental Health: _____
☐ Test Done ☐ Lead Elevated ≥ 10 $\mu\text{g/dL}$				☐ Other: _____
☐ System Review and Exam Entirely Normal				
Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities				
☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal
☐ Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code
			_____	_____
			_____	_____
			_____	_____
☐ Additional Information Attached				

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	Negative	Positive	Referral	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
☐ Full Activity without restrictions including Physical Education and Athletics.				
☐ Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications				
☐ No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling				
☐ No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field				
☐ Other Restrictions:				
☐ Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V				
☐ Accommodations: Use additional space below to explain				
☐ Brace*/Orthotic		☐ Colostomy Appliance*		☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*		☐ Medical/Prosthetic Device*		☐ Pacemaker/Defibrillator*
☐ Protective Equipment		☐ Sport Safety Goggles		☐ Other:
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
☐ Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
☐ Record Attached		☐ Reported in NYSIIS		Received Today: ☐ Yes ☐ No
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

**2026-2027 WCSD Emergency
Procedure Information Grades K - 12**

For Office Use Only
Student ID# _____

Student Name _____ Home Telephone # _____

Last

First

Grade _____ Date of Birth ____/____/____ Teacher/Homeroom _____ Bus # _____

Street Address _____ City _____ Zip _____

Mailing Address _____ City _____ Zip _____

Name of Primary Household Parent/Guardian _____

Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____

Name of Secondary Household Parent/Guardian _____

Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____

Siblings living in household:

Name _____ DOB ____/____/____ School _____ \ Name _____ DOB ____/____/____ School _____

Name _____ DOB ____/____/____ School _____ \ Name _____ DOB ____/____/____ School _____

Name _____ DOB ____/____/____ School _____ \ Name _____ DOB ____/____/____ School _____

****Relationship and name of person(s) with whom student resides: **** _____

****Name and Address of Parent NOT Residing with Student: **** _____

Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____

#2 Street Address _____ City _____ Zip _____

#2 Mailing Address _____ City _____ Zip _____

****List persons other than yourself who will assume temporary care of your child for an illness or emergency.**

****Please advise these individuals you are listing them for emergency care. [ID will be requested].**

Name _____ Relationship _____ Telephone # _____

Name _____ Relationship _____ Telephone # _____

Name _____ Relationship _____ Telephone # _____

Name _____ Relationship _____ Telephone # _____

Name _____ Relationship _____ Telephone # _____

Name _____ Relationship _____ Telephone # _____

Where will the bus pick up and drop off your child? **For Elementary Use Only**

Morning Pick-Up (check one) ☐ Home ☐ Sitter's

Afternoon Drop-Off (check one) ☐ Home ☐ Sitter's

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

If your child is picked up or dropped-off at Child-Care Giver (Babysitter)

Name _____ Telephone # _____

Apartment/Street _____ City _____

Please initial each item you have received. Discipline Code _____ Internet Policy _____ Media _____

Signature Primary Household Parent /Guardian _____ Date ____/____/____

Signature Secondary Household Parent /Guardian _____ Date ____/____/____

Wallkill Central School District
Student Registration Form 2026-2027

For Office Use Only
Student ID# _____

Date ____/____/____

DOB ____/____/____

Student's NAME _____
Last First Middle

GENDER (check one) ☐ M ☐ F ☐ Non-Binary

SPECIAL EDUCATION SERVICES (check one) ☐ Yes ☐ No [If Yes, Please Provide IEP]

ETHNICITY (check one)

- ☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ RACE (check one)

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

FAMILY INFORMATION

Languages spoken at home _____

Student's language _____

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

Student's place of birth _____

City State
Custodial Papers (check one) ☐ Yes ☐ No [If Yes, Please Provide]

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

Foster home placement? (check one) ☐ Yes ☐ No

Agency Name/Address _____

Agency Telephone Number _____

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

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

To Be Completed by School District
Cohort Year Entering 9th Grade) _____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

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

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.		
STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
☐ Male ☐ Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)	
1. What language(s) is(are) spoken in the student's home or residence?	☐ English ☐ Other specify
2. What was the first language your child learned?	☐ English ☐ Other specify
3. What is the Home Language of each parent/guardian?	☐ Mother specify ☐ Father specify ☐ Guardian(s) specify
4. What language(s) does your child understand?	☐ English ☐ Other specify
5. What language(s) does your child speak?	☐ English ☐ Other specify ☐ Does not speak
6. What language(s) does your child read?	☐ English ☐ Other specify ☐ Does not read
7. What language(s) does your child write?	☐ English ☐ Other specify ☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

Wallkill CSD PO Box 310, Wallkill, NY
District Name (Number) & School Address

STUDENT ID NUMBER IN NYS STUDENT
INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History	
8. Indicate the total number of years that your child has been enrolled in school _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. Yes* ☐ No ☐ Not sure ☐ *If yes, please explain: _____	
How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? ☐ No ☐ Yes* <i>*Please complete 10b below</i>	
10b. <i>*If referred for an evaluation</i> , has your child ever <u>received</u> any special education services in the past? ☐ No ☐ Yes – Type of services received: _____	
Age at which services received <i>(Please check all that apply)</i> : ☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes	
11. Is there anything else you think is important for the school to know about your child? <i>(e.g., special talents, health concerns, etc.)</i> 	
12. In what language(s) would you like to receive information from the school? _____	

Signature of Parent or of Person in Parental Relation

Month: _____
Day: _____
Year: _____

Date

Relationship to student: ☐ Mother ☐ Father ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes	
**DATE OF INDIVIDUAL INTERVIEW: MO. _____ DAY _____ YR. _____	OUTCOME OF INDIVIDUAL INTERVIEW: ☐ ADMINISTER NYSITELL ☐ ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: MO. _____ DAY _____ YR. _____	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	



Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
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Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:

Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas. Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre Segundo nombre Apellido

FECHA DE NACIMIENTO:

GÉNERO:

Mes Día Año

☐ Masculino
☐ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido Primer Nombre Relación con el estudiante

CÓDIGO DEL
IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?

☐ Inglés ☐ Otro

especifique

2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?

☐ Inglés ☐ Otro

especifique

3. ¿Cuál es el idioma primario de cada padre / tutor?

☐ Madre

☐ Padre

☐ Tutor(es)

especifique

especifique

especifique

4. ¿Qué idioma o idiomas entiende su hijo(a)?

☐ Inglés ☐ Otro

especifique

5. ¿Qué idioma o idiomas habla su hijo(a)?

☐ Inglés ☐ Otro

☐ No sabe hablar

especifique

6. ¿Qué idioma o idiomas lee su hijo(a)?

☐ Inglés ☐ Otro

☐ No sabe leer

especifique

7. ¿Qué idioma o idiomas escribe su hijo(a)?

☐ Inglés ☐ Otro

☐ No sabe escribir

especifique

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Wallkill CSD PO Box 310, Wallkill, NY

District Name (Number) & School

Address

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo	
8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____	
9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.	
Sí* ☐ No ☐ No se sabe ☐	* En caso afirmativo, por favor explique: _____
¿Qué gravedad considera usted que tienen estas dificultades educacionales? ☐ Poca gravedad ☐ Algo grave ☐ Muy grave	
10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ☐ No ☐ Sí* * Por favor, llene 10b.	
10b. <u>*Si se le ha recomendado alguna vez una evaluación,</u> ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?	
☐ No ☐ Sí – Explique, que forma o formas de educación especial recibió: _____	
Edad en la que recibió la intervención o forma de educación especial (favor de marcar todas las opciones que sean aplicables): ☐ De nacimiento a 3 años (Intervención Temprana) ☐ 3 a 5 años (Educación Especial) ☐ 6 años o mayor (Educación Especial)	
10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ☐ No ☐ Sí	
11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)? (Por ejemplo, talentos especiales, problemas de salud, etc.) _____ _____ _____	
12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____	

Mes: _____ Día: _____ Año: _____

Firma del padre/madre o de la persona en relación paternal _____
Date

Relación con el estudiante: ☐ Madre ☐ Padre ☐ Otra: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
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NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ Mo. DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: ☐ ADMINISTER NYSITELL ☐ ENGLISH PROFICIENT ☐ REFER TO LANGUAGE PROFICIENCY TEAM
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NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ Mo. DAY YR.	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	

**Wallkill Central School District
2026-2027 Media Release**

Student Name: _____ **Birth Date:** _____



1. Media Coverage Release Form for Students

Your permission is required for your child to be photographed, interviewed or mentioned by name in any media coverage, which might take place in or about the school district throughout the school year. This includes newspapers, periodicals, television, cable television, radio, and school district publications.

PLEASE CHOOSE ONE

- ☐ I hereby GIVE permission for my child to be photographed, interviewed, televised or mentioned by name in media coverage of school district events.
- ☐ I hereby DENY permission for my child to be photographed, interviewed, televised, or mentioned by name in media coverage of school district events.

Parent/Guardian Signature

Date

Military/Armed Forces Family Questionnaire

As part of the new accountability requirements under Every Student Succeeds Act (ESSA), the U.S. Department of Education is requiring school districts to identify students who are armed forces family members.

In an effort to identify our military/armed forces students, please respond to the following:

Student Name: _____

Date of Birth:

ID #:

Student Grade:

Is either Parent/Guardian a member of the Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) on **active duty** or **full-time** National Guard duty?

☐

YES

☐

NO

IF YOUR STATUS SHOULD CHANGE FROM ACTIVE TO NON-ACTIVE, please notify the District registrar (Tracy Rohl) at (845) 895-7105 or trohl@wallkillcsd.k12.ny.us.

- “Active Duty” means full-time duty in the active military service of the United States. Such terms include full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.
- “Full-Time National Guard duty” means training or other duty, other than inactive duty, performed by a member of the Army National Guard of the United States or the Air National Guard of the United States in the Member’s status as a member of the National Guard of a State or territory, the Commonwealth of Puerto Rico, or the District of Columbia under Section 316, 502, 503, 504, or 505 of Title 32 of the United States Code, for which the member is entitled to pay from the United States or for which the member has waived pay for the United States.