Kerhonkson Elementary School

Jackie VanNosdall, Principal
P.O. Box 9
Accord, NY 12404
(845) 626-2451
jvannosdall@rondout.k12.ny.us or kesoffice@rondout.k12.ny.us

Dear Parent/Guardian:

Welcome to the Rondout Valley Central School District!

Please follow the attached Student Registration Check-Off List to assure that you have all the necessary documents for school enrollment registration. If you have any school records, such as progress notes or report cards, please include them.

Please remember to sign and date all forms that require your signature.

All documents are required for each child that you are registering for school.

Upon receipt of the completed documents, we will begin the registration process. If you have any questions at any time, please feel free to call for assistance.

Thank you!

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❑ Student Registration Check-Off List

- ❑ School Registration Form **(Form #1)**
- ❑ Original Birth Certificate (for us to copy)
- ❑ Student Health Information Form **(Form #2)**
- ❑ Immunization Record (for us to copy)
- ❑ Residency Verification: 2 Required **(Form #3)**
- ❑ Emergency Contact Information **(Form #4)**
- ❑ Transportation Form **(Form #5)**
- ❑ Release of School Records **(Form #6)**
- ❑ Home Language Questionnaire **(Form #7)**

If applicable:

- ❑ Please submit any documents that apply to custody arrangements for your child

Form #1

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT – REGISTRATION FORM

SHADED AREAS FOR OFFICE USE ONLY		
Entry Date: / Student ID#		School Year:
School: KES MES IS JRH HS	Birth Certificate:	Cohort Year:
New Student Returning Student	Entering Grade:	Graduation Date:

Student First Name	Middle Name
Student Last Name	
Physical Address (Street Address) (City) (State) (Zip)	
Mailing Address (if different) (PO Box/address) (City) (State) (Zip)	
Town/Village of Residence	Email Address: Parent/Legal Guardian (Please circle one)
Parent/Legal Guardian's Name:	Parent/Legal Guardian's Name:
Student's Sex M F / Student's Date of Birth:	Special Programs/IEP:
Student's Place of Birth (City) (State) (Zip)	Date of Entry (if not born in US) / Country of Origin
Number of years in US Schools:	What languages does the student understand?
Home Language	What language does student: Read Write
Race (circle one) Hispanic Non-Hispanic	International Adoption? YES NO Date of Adoption ___________
Ethnicity (circle one): I – American Indian or Native America A – Asian B- Black or African American H – Hispanic or Latino P – Native American or other Pacific Islander W - White	Citizenship Status (check one) Dual Nation: ______ Non-resident alien: ______ US Citizen: ______ Other: ______ Date of 1st Polio Immunization:

RESIDENCY INFORMATION –(please circle one)

Student lives with: Both Parents Father Mother Legal Guardian Stepparent

Relative Relationship: ____________________

Foster Home PLEASE NOTE PLACEMENT AGENCY & ADDRESS:

____

____

STUDENT LIVING ARRANGEMENTS

Question		
Is the student homeless?	YES	NO
Is the student living in a shelter:	YES	NO
Is the student living with relatives due to lack of housing?	YES	NO
Is the student living in an abandoned apartment/building?	YES	NO
Is the student living in a motel/hotel?	YES	NO
Is the student living in a campground, car, train/bus station or other similar situation due to lack of alternative, adequate housing?	YES	NO
Is the student temporarily housed in a shelter awaiting OCF'S permanent foster care placement?	YES	NO

TELEPHONE NUMBERS

(Fill out employer information only for parent(s), Legal Guardian or Relative that student lives with)

	HOME#	WORK#	CELL#
Parent/Legal Guardian			
Parent/Legal Guardian Employer			
Parent/Legal Guardian			
Parent/Legal Guardian Employer			
Guardian			
Guardian's Employer			
Relative			
Relative's Employer			

****EMERGENCY NUMBERS****

Name	Relationship
Address	Permission to pick up student: YES NO
Phone #	Cell #
Name	Relationship
Address	Permission to pick up student: YES NO
Phone #	Cell #

STUDENT HISTORY	
Previous School	Address
List Areas of Residence for Last Five Years	

FAMILY HISTORY		
Parent/Legal Guardian (Last Name)	(First Name)	(Middle Initial)
Birthdate:	Place of Birth: (City) (State)	
Residence if other than child's:		
Education:		
Occupation:	Email Address:	
Parent/Legal Guardian (Last Name)	(First Name)	(Middle Initial)
Birthdate:	Place of Birth: (City) (State)	
Residence if other than child's		
Education:		
Occupation:	Email Address:	
Guardian: (Last Name)	(First Name)	(Middle Initial)
Birthdate:	Place of Birth: (City) (State)	
Residence if other than child's		
Education:		
Occupation:	Email Address:	

Stepparent: (Last Name)	(First Name)	(Middle Initial)
Birthdate:	Place of Birth: (City) (State)	
Residence if other than child's		
Education:		
Occupation:		

OTHER CHILDREN

	Sex	Date of Birth	Attending Rondout?	
Brother's Names			Yes	No
Sister's Names				

Note here any home, medical, custody, or school situation the school needs to know.

____

____

Registration form signed by:

______________________________ ______________________

Signature of Parent/Legal Guardian Date

Form #2

Kerhonkson Elementary School PO Box 9, Accord, NY 12404 845-626-2451

Student Health Information Form

Child's Name________________________________Child's Birthdate_____________ Age_____Grade_____

Who is filling out this form?

☐ Mother ☐ Father Your Name____

☐ Other (please explain relationship to child)__________________________________

MEDICAL HISTORY

1. Were there any issues during pregnancy, labor and/or delivery for this child?

☐ No Birth Weight ___________

☐ Yes

If yes, please describe: ____

____

2. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No

☐ Yes (If yes, explain why and when below.)

____

____

My child was in the hospital because:	When

3. Is your child taking any **prescription medicines**?

☐ Yes - Please list the child's medicines below OR

☐ No. My child does not take any prescription medicines. (If no, go to question #3)

☐ Yes ☐ No. Does your child use an inhaler or breathing treatments? If **YES**, please list medicine below.

Name of medicine	Amount / size of pill	How many pills or doses does your child take at
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

4. What **over-the-counter medicines** does your child take **regularly**?

☐ Vitamins

☐ Herbal medicine (please list) ____

☐ Other medicines like Tylenol, Advil or something else? (please list)_____________________

____

☐ **None**, my child does not take any over-the-counter medicines regularly.

** Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there is health information you would like not to be shared, please contact the school nurse.*

Turn page over please!

(02/2015)

5. Does your child have any **allergic reaction** (bad effect) from any of the following? (Check all that apply.)

☐ Outside or Indoor allergies, (*for example: hayfever, grass, pollen, cats ...*) **Please list below ↓**

☐ Food Allergies (*for example: peanuts, milk, wheat ...*) **Please list below ↓**

☐ Insect or Animal Allergies (*for example: bees, wasps, cats...*) **Please list below ↓**

☐ Medicine or shots (*immunization*). **Please list below ↓**

☐ **No**, my child has no allergies that I know of.

Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

My child is allergic to:	What happens when your child has a reaction?

6. Has your child had any of the following **medical problems or injuries**? (examples in parenthesis)
Describe **your child's** problem for each ☒**Yes** on the lines at the bottom of the page ↓ .

Chicken Pox--Date if had chickenpox:	☐ Yes ☐ No
Surgery --Date of any surgeries:	☐ Yes ☐ No
Head Injury or **Concussion**	☐ Yes ☐ No
Ear infections *(often has them, ear tubes, etc)*	☐ Yes ☐ No
Nose problems *(sinus infections, nose bleeds)*	☐ Yes ☐ No
Eye problems *(blurry vision, wears glasses, lazy eye)*	☐ Yes ☐ No
----Should **wear glasses or contacts** to see ☐ far away ☐ read	
Hearing problems *(has trouble sometimes, wears hearing aid)*	☐ Yes ☐ No
Mouth or throat problems *(Strep throat, swallowing problems)*	☐ Yes ☐ No
Constipation *(problems having a bowel movement (BM))*	☐ Yes ☐ No
Problems **peeing** *(bed wetting, pain when peeing)*	☐ Yes ☐ No
Back problems *(crooked back, back pain)*	☐ Yes ☐ No
Muscle and bone problems *(weak muscles, pain in joints)*	☐ Yes ☐ No
Skin problems *(acne, flaking skin, rashes, hives)*	☐ Yes ☐ No
Seizures *(shaking fits or convulsions)*	☐ Yes ☐ No
ADD/ADHD *(problems paying attention, sitting still)*	☐ Yes ☐ No
Breathing problems *(cough, asthma)*	☐ Yes ☐ No
Heart problems *(fast or irregular heart beat, murmur, birth defect)*	☐ Yes ☐ No
Feelings or emotions *(depression, anxiety, fears)*	☐ Yes ☐ No
Other:	☐ Yes ☐ No

Did you ☒**Yes** for any problems above? **Tell us more here:**____________________

____

Signature of person filling out form

Date filled out

Form #3

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT

PO Box 9
Accord, New York 12404
845-687-2400
845-687-0945 Fax

Please provide two proofs.

RESIDENCE VERIFICATION

I hereby certify that:

______________________________ resides with me at
(Student's Name)

____
(Street Address & Town

______________________________ is a bonafide resident of
(Student Name)

Rondout Valley Central School District as evidenced by the fact that he/she lives at the residence on a permanent basis*.

______________________________ has no other residence
(Student Name)

or domicile** and my relationship to ______________________________
(Student Name)

is ______________________________
(Relationship to Student)

______________________________ ____________________
(Signature) (Date)

* A permanent basis means that this child sleeps at your residence during the week and on weekends, and spends vacations and holidays at your residence. This takes into consideration that there are times a child can be away from home for vacations, to visit relatives, or to sleep over at a friend's house.

** A domicile is a place, which an individual considers his permanent home.

Form #4

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
Kerhonkson Elementary School
P.O. Box 9, Accord, NY 12404
(845) 626-2451

MAIN OFFICE
REQUEST FOR EMERGENCY INFORMATION

In order to keep our emergency information on your child up-to-date, your cooperation in filling out this form is required. Thank you, in advance, for your assistance.

Child's Name: ______________________________ ______________
Last First M.I. Homeroom Teacher

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other ______________
Relationship

Home Address ______________________________ ______________
Home Telephone

Mailing Address ______________________________ ______________
(If different from above) Cell Phone Number

Email Address ______________________________

______________ ______________________________
Parent's Name If employed, business name, address and telephone

______________ ______________________________
Parent's Name If employed, business name, address and telephone

Emergency persons who can be contacted in the event parents cannot be reached:

1) Name ______________________________ ______________
Relationship

Address ______________________________ ______________
______________________________ Telephone

____
Permission to pick up student: YES NO (Circle One) Cell Phone Number

2) Name ______________________________ ______________
Relationship

Address ______________________________ ______________
______________________________ Telephone

____
Permission to pick up student: YES NO (Circle One) Cell Phone Number

OVER ➔

Emergency persons who can be contacted in the event parents cannot be reached:

3) Name____ ______________________
Relationship

Address ____ ______________________
Telephone

____ ______________________
Cell Phone Number

Permission to pick up student: YES NO (Circle One)

4) Name____ ______________________
Relationship

Address ____ ______________________
Telephone

____ ______________________
Cell Phone Number

Permission to pick up student: YES NO (Circle One)

______________________________ ______________
Parent's Signature Date

Form #5

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
TRANSPORTATION FORM

Student ID# ________________ (For office use)   Family ID# ________________ (For office use)

Student's Name ____ Sex: M _____ F _____

Grade: ________________   Date of Birth ______________

Student Lives with: Please circle one: Both Parents   Father   Mother   Guardian   Relative

Parent's Name ____

____

Guardian / Relative Name ____

____

Physical address: ____

____
City   State   Zip Code

Mailing address (if different from physical address) ________________________________

____
City   State   Zip Code

	Father	Mother	Guardian / Relative
Home Phone Number:	________________	________________	________________
Work Phone Number:	________________	________________	________________
Cell Phone Number:	________________	________________	________________

Phone number to be contacted in case of emergency:

Name: ________________________________

Relationship to student: ________________________   Phone number: ________________

Form #6

RONDOUT VALLEY CENTRAL SCHOOL DISTRICT
KERHONKSON ELEMENTARY SCHOOL
P.O. Box 9, Accord, NY 12404
(845) 626-2451

RELEASE OF RECORDS

STUDENT ______________________________ **DATE** __________
(Last Name) (First Name)

GRADE AND TEACHER ______________________________

I hereby give my permission to release all educational, health and psychological records on file at:

____

____

____

PLEASE MAIL TO: KERHONKSON ELEMENTARY SCHOOL
P.O. Box 9
Accord, NY 12404

OR FAX: (845) 626-5767

New Home Address: __________________

____

____

____
(Signature of Parent/Guardian)

____
(Date)

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

Lissette Colon-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:

Month *Day* *Year*

GENDER:
❑ 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.)

Question			
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* ❑ Guardian(s) ________ *specify*	❑ Father ________ *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:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school ___________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ *If yes, please explain:___________

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ No ❑ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ No ❑ Yes – Type of services received:___________

Age at which services received *(Please check all that apply):*
❑ Birth to 3 years (Early Intervention) ❑ 3 to 5 years (Special Education) ❑ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ❑ No ❑ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? ___________

___________ Month: Day: Year:

Signature of Parent or of Person in Parental Relation *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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: