



Mohonasen Central School District

2072 Curry Road, Schenectady, New York 12303

518-356-8222 Phone 518-356-8247 Fax vgannon@mohonasen.org

To Families Registering Preschool Aged Children

*The Central Registration Office is located in the District Offices at 2072 Curry Road. Completed packets may be left in the dropbox located outside the office doors, emailed or faxed. **Incomplete packets cannot be processed.** Once the student is registered, the paperwork will be given to the Special Education Department and they will contact you. Thank you for your cooperation.*

Proof of Residency

One of the following items with your name and address, dated within the last 30 days:

- 1) If you are a renter, **provide a current lease** which includes the landlord's name, address and contact number.
- 2) If you are a renter **without a current lease**, provide a current rent receipt with the landlord's name, address and phone number as we will need to call and speak with them.
- 3) If you are a homeowner, provide a current tax bill, deed or mortgage statement.
- 4) If you have just had your closing, closing documents and realtor information
- 5) **If you are moving in with someone else and you do NOT own the home**, that individual must provide one of the documents listed above and sign a notarized statement regarding residency. **The homeowner and parent must sign separate documents and have them notarized** and you must provide the items listed below.

License and vehicle registration with your current address.

Two of the following items with your name and current address dated within the last 30 days. THESE ITEMS ARE REQUIRED EVEN IF YOU RECENTLY MOVED:

- 1) National Grid or Spectrum bill
- 2) Current pay stub
- 3) Bank and/or credit union statement
- 4) Income tax forms
- 5) Homeowners or renters insurance
- 6) Documents issued by federal, state or local agencies
- 7) Completed change of address document from the post office

Continued on back page

Students proof of age

Provide one of the following documents to show proof of age:

- 1) Child's birth certificate
- 2) Passport
- 3) Baptism certificate

Alternate Forms of proof of age if one of the above cannot be provided:

- 1) Student license or permit
- 2) State or other government issued identification
- 3) Hospital or health records
- 4) Military dependent identification card
- 5) Documents issued by federal, state or local agencies
- 6) Court ordered documents
- 7) Native American tribal documents

OTHER MANDATORY STUDENT INFORMATION

- 1) Immunization records and current physical. The registration packet may not be processed without this!
- 2) Custody paperwork if applicable. If the student is not your biological child, an official court generated document that proves a permanent and total transfer of custody and control of the student to you must be provided.
- 3) Child's IEP (Individual Education Plan), if applicable
- 4) Child's 504 plan, if applicable
- 5) Last report card or transcript
- 6) Foster children, DSS-2999 form must be provided

Current proof of residency is required and needs to be presented at the time of the registration appointment even if you have another child in the district.

Incomplete packets cannot be processed

Feel free to contact the District Registrar, Mrs. Gannon, at 518-356-8222 with any questions

Mohonasen Central School District New Student Registration Form

*Please print **clearly**, all information is entered into the students School Tool account from this paperwork.

School Year: _____

Student Data:

Student Name **as listed on birth certificate:** _____

Alternate Student Name or Nickname: _____

Date of Birth: ____/____/____ Circle one: Male Female Non-Binary

Address: _____

Is this for a pre-school evaluation? YES ____ NO ____

Grade at Entry: _____ School(Circle one): Bradt(K-2) Pinewood(3-5) Draper(6-8) High School(9-12) Private/ Parochial---Name of school: _____

Is the student a: Foreign Exchange Student, Refugee or Immigrant: Yes/No Country: _____

Student lives with(check all that apply):

___Mother ___Father ___Guardian ___Step-Mother ___Step-Father

___Siblings ___Grandmother ___Grandfather ___Foster Parent (attach DSS 2999 form)

___Other _____

Please list all children living in the home:

Name: _____ DOB/sex: _____ Grade: _____ School: _____

Family Data:

Parent/Guardian: _____

Spouse/Other: _____

Relationship to Child: _____

Relationship to Child: _____

Address: _____

Address: _____

Cell Phone: _____

Cell Phone: _____

Home Phone: (If there is one, if not leave blank)

Home Phone: _____

Work phone#: _____

Work Phone: _____

Email Address: _____

Email Address: _____

Occupation: _____

Occupation: _____

New Student Registration form continued

Special Needs of the Child:

Is your child identified by the Committee on Special Education? YES ____ NO ____

Does your child have a 504 plan or an IEP? YES ____ Circle one: IEP/504 NO ____

Are there any legal or custodial restrictions? YES ____ NO ____

*If yes, a court document is required and must be attached.

Is there any other relevant information? YES ____ NO ____

*If yes, please explain: _____

Previous information that is required:

Previous address: _____

Previous school attended with name, address and phone number for the school:

Other schools attended if prior school is less than 3 years: _____

Has the student repeated a grade: YES ____ NO ____ If YES, which grade? ____

Parent Statement: I certify that the above information is true and correct. Any misinformation regarding residency could result in being billed the tuition and exclusion from attending Mohonasen Central Schools.

Parent signature: _____ Date: _____

Office use only: Proof of Residency:

One of the following:

School Taxes/Deed/Mortgage Statement _____ Lease Agreement _____

Notarized Statement from Homeowner _____ w/ 1 proof _____

Notarized Statement from Parent _____

And at least two of the following documents:

Utility Bill _____ Insurance Bill _____ Paycheck _____ Bank Statement _____

Change of Address _____ Other _____ Other _____

AND

Vehicle Registration _____ License _____ Current Address? Yes/No

Registered by: _____ Date: _____ Expected Start Date: _____

Notes/Comment section:

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<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
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure:
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	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: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				

System Review and Abnormal Findings Listed Below

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

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	



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

Lisette 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
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify _____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not write

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

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Maharajen CSD 2012 Curry Rd 12038
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:

Vanessa

Registrar

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:

Rotterdam-Mohonasen Central School District
RESIDENCY QUESTIONNAIRE

Name of LEA: Rotterdam-Mohonasen CSD

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Male Date of Birth: ____/____/____ Grade: ____ ID#: _____
 Female Month Day Year (preschool-12) (optional)

Current Address: _____ Phone: _____

Previous Address: _____

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 permanent housing (this includes apartments with a rental agreement)
- In a shelter
- With another family or other person (sometimes referred to as "doubled-up") due to a loss of housing, economic hardship, or similar reason
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): _____

* _____
Print name of Parent, Guardian, or Student
(for unaccompanied homeless youth)

* _____
Signature of Parent, Guardian, or Student
(for unaccompanied homeless youth)

Date

If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Mohonasen Central School District
Student Racial and Ethnic Identification Form

Student Name: _____

Date of Birth: _____

Grade: _____

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South America, or other Spanish Culture of origin regardless of race.

YES, Hispanic

NO, not Hispanic

2. Select one of more of the races from the following 5 racial groups. Check all groups that apply, but you must check at least one.

- American Indian or Alaskan Native** – a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment
- Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam
- Native Hawaiian or other Pacific Islander** - a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- Black or African American** – a person having origins in any of the Black racial groups of Africa
- White** - a person having origins in any of the original peoples of Europe, North Africa or the Middle East

Signature of Parent/Guardian

Date

Relationship to Student (please mark one below)

____ Mother ____ Father ____ Guardian ____ Other: _____

Mohonasen Central School District
2072 Curry Road
Schenectady, New York 12303
Phone - 518-356-8222

Mohonasen High School
2072 Curry Rd.
Schenectady, NY 12303
Fax: 518-356-8247
Phone: 518-356-8222

Draper Middle School
2070 Curry Rd.
Schenectady, NY 12303
Fax: 518-356-8359
Phone: 518-356-8351

Pinewood Elementary School
901 Kings Rd.
Schenectady, NY 12303
Fax: 518-356-8434
Phone: 518-356-8431

Bradt Elementary School
2719 Hamburg St.
Schenectady, NY 12303
Fax: 518-356-8404
Phone: 518-356-8401

CONSENT AND AUTHORIZATION FOR RELEASE OF RECORDS

TO: _____

RE: Request and Consent for Release of Records and Information

I, _____, parent of _____, in
(Name of parent) (Name of student)

Grade _____, request and consent to the release of any information pertaining to my child named above to *Mohonasen School District* where my child now attends. I also authorize you to discuss my child/children(s) condition, the course of treatment and your recommendations with the following representatives of the Mohonasen School District for the purposes of educational planning.

(List names and titles of authorized individuals in the space provided below)

_____	_____
(Name)	(Title)
_____	_____
(Name)	(Title)

Please fax the records of the student listed above to the attention of _____ at the above fax number or mail to the address appearing on the letterhead.

Thank you in advance for your cooperation. If you have any questions, please do not hesitate to call the number listed above.

(Signature of Parent) _____

Print Name _____

Relationship to Student/Patient _____

Date _____

This authorization, unless revoked in writing, will remain in effect for one year from the date signed.

Copies to: Pupil Personnel Services _____

School Building _____

*****ATTENTION*****

If your answer is NO,
put an X on this line _____
AND sign by parent/guardian.



IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

* Parent/Guardian Name: _____

Home address: _____

Telephone number: (____)-____-____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

To submit this referral please fax to 607-436-3606, or by mail to NYS Migrant Education Program- Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

Mohonasen Central School District
2072 Curry Road
Schenectady, NY 12303

**PLEASE FILL OUT!
NEEDED FOR SCHOOL
RECORDS.**

Dear Parent/ Guardian of _____:

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 program (IEP).

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____, as the parent/guardian of _____
(Print child's name) have received a written notification from

The school district 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 may 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;
- I have the right to withdraw consent at any time; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared: service records related to Occupational Therapy, Physical Therapy, Speech/Language Therapy, Psychological Counseling, or Nursing Services that your child receives.

I give my consent voluntarily and understand that I may withdraw my 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.

Medicaid ID/CIN #, if applicable _____

Parent/Guardian Signature: _____

Print Name: _____ Date: _____