REGISTRATION FORM

GREATER JOHNSTOWN SCHOOL DISTRICT

1 Sir Bills Circle, Johnstown, NY 12095

Student's Full Legal Name: _____
(First) (Middle) (Last)

Sex: _____Male _____Female Grade: _____ Date of Birth _____

Street Address (Actual Residence not PO Box): _____
Street number and Name

_____, New York Zip Code: _____
City/Village

Mailing Address (PO Box Acceptable): _____

Parent/Guardian: _____
Name

Home Telephone: _____

Cell Number: _____

Work Number: _____

E-mail address: _____

Custody: Child's legal custodian is _____ Relationship: _____

Child lives with: _____ Relationship: _____

Is there a custody issue? _____

*If custodial rights have been altered, then proof must be in writing. See below for acceptable proof.

Order of Protection* ___ (*If an order of protection exists, it must be submitted to building principal at time of student enrollment)

Parent/Guardian Information

	Name	Home Address	Work Place and Phone Number
Mother (include maiden name)			
Father			
Step Parent			
Legal Guardian			

Is this a foster placement: _____ Yes _____ No

If yes, name of county _____

If yes, copy of DSS 2999 Form required

☐ **Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement _____ (living arrangements). If box is checked, please complete STAC-202 form. The answer you give 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.**

Brother(s) and Sister(s) Information

Name (First and Last)	Sex	Birth Date	Living at Home	Present Grade	School Attending

What Mode of Communication does/do the Parent(s) prefer:

[ ] Written Notice [ ] Phone Calls [ ] Email [ ] Person to Person

_____ Date: _____

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

Business Office Signature	**Date**

PROOF OF VERIFICATION OF AGE PROVIDED:

[ ] Birth Certificate
[ ] Baptismal Certificate
[ ] Other (see list below): _____

EVIDENCE OF CUSTODY PROVIDED:

[ ] Judicial Custody Papers
[ ] Guardianship papers
[ ] Signed affidavits

PROOF OF RESIDENCY PROVIDED:

[ ] Copy of Deed
[ ] Copy of Purchase Contract, with Letter from Attorney (including date/time of closing)
[ ] Lease Agreement or Statement from Landlord, Owner or Tenant from whom you lease or live with
[ ] Third party statement establishing the physical presence of the parent(s)/guardian(s) in the school district
[ ] Other (see list below): _____

Other proofs of Age:

Passport;
Official driver's license;
State or other government issued identification;
School photo identification with date of birth;
Consulate identification card;
Hospital or health records;
Military dependent identification card;
Documents issued by federal, state or local agencies;
Court orders or other court-issued documents;
Native American tribal documents'

Other proofs of Residency:

Pay Stub;
Income tax form;
Utility or other bills;
Membership documents based upon residency (e.g. library cards)
Voter registration document(s)
State or other government issued ID
Documents issued by federal, state, or local agencies.

GREATER JOHNSTOWN SCHOOL DISTRICT
1 Sir Bills Circle, Johnstown, NY 12095
(To be completed after student is enrolled)

Racial/Ethnic Identification – please answer both of the following questions.

1. Is the student Hispanic, Latino or of Spanish origin? Hispanic, Latino or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
   Yes ____ No ____

2. Select one or more races from the following five racial groups: (Check all groups that apply to your child.)

   ☐ American Indian or Alaska Native – a person having origins in any of the original peoples of North America

   ☐ Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent

   ☐ 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 – 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

3. What language does/do the parent(s) prefer to speak?
   ☐ English
   ☐ Other: _____
   (Please specify)

_____

Signature of person filling out form Relationship Date

Revised 5/6/15
bbt

Greater Johnstown School District
Johnstown, NY 12095

EMERGENCY CONTACT INFORMATION AUTHORIZATION

In order to adequately care for your child when he/she is in school, we need to have up-to-date information about your child's care, as well as a current health and medical history. Please complete this form and return it to the school immediately.

Student's Name _____ _____ _____
Last First M.I. Grade Building

Birthdate _____ Sex _____

Siblings attending Johnstown Schools (include name, grade and school) _____

_____

Student lives with: ___ Parents ___ Mother ___ Father ___ Guardian

_____
Father/Guardian Home Address Home Phone Work Phone

_____
Mother/Guardian Home Address Home Phone Work Phone

Children will be released to parent/guardians and only those others listed below. This includes releases for any purpose, at any time, including at dismissal. Be sure to list all individuals that you may delegate for this responsibility and include all information. If there are any changes during the year, please contact the main office of your child's school to report them.

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

_____
Name Relationship Address Phone

Please complete back of form

Revised 2/14

Greater Johnstown School District
Johnstown, NY 12095

Health Record Update

Student Name _____ Grade _____

☐ *Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station. If the students lives with relatives or others due to lack of housing or other similar situation, or if the student is temporarily housed in a shelter awaiting permanent foster care placement.* _____

CHILD FIND – The Greater Johnstown School District has an obligation to evaluate, with parental consent, and offer to students determined to be disabled who reside in the District, a free and appropriate public education. If you believe your child has a disability that requires specialized instruction or special accommodations to benefit and/or access our programs and services, please contact your child's building principal or the Director of Special Education at 518-736-1708 to discuss the process to initiate a referral to the Committee on Special Education or the §504 Team. If you suspect your child has a disability which adversely affects his/her educational performance and which may require special education and you are enrolling your child in a nonpublic school and are seeking supports for your child while he/she attends school there, you may initiate a referral by writing to the CSE in the school district where the nonpublic school is located.

Does your child have or recently been diagnosed with asthma?	**YES**	**NO**
Does your child have any significant allergies (peanut, bee sting, latex, etc)?	**YES**	**NO**
Does your child have a seizure disorder as diagnosed by a physician?	**YES**	**NO**
Does your child have diabetes?	**YES**	**NO**
Does your child wear glasses or contacts?	**YES**	**NO**
Does your child wear a hearing aide or suffer from a hearing problem?	**YES**	**NO**
Has your child sustained any significant injury, surgical procedure, or recent hospitalization?	**YES**	**NO**
Does your child take any medication on a regular basis?	**YES**	**NO**

If you have answered YES to any of the above questions, please explain the specific conditions, the specific type of allergy, any activity restrictions, any special care required, the name and dosage of any prescribed medications.

Please list and explain any other health concerns you have for your child.

_____

_____

_____

I hereby give the Health Office permission to share this information with the school staff for the safety of my child.

_____ _____
Parent/Guardian Signature Date

In an emergency, when reasonable attempts to reach those people I have identified on the Emergency contact Information Form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred physician or dentist is not available, by another physician or dentist, and the transfer of my child to ANY hospital readily accessible.

_____ _____
Parent/Guardian Signature Date

Refusal To Consent

I do not give my permission for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to _____

_____

_____ _____
Parent/Guardian Signature Date

Revised 7/10

GREATER JOHNSTOWN SCHOOL DISTRICT

Administration Center
1 Sir Bills Circle, Suite 101 ◆ Johnstown, NY 12095
Phone (518) 762-4611
Fax: (518) 762-6379

Dr. Patricia Kilburn
Superintendent of Schools

RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby request and authorize the release of all current records: report cards/academic grades; health records (immunizations and physical examinations); psychological/psychiatric evaluations; IEP (Individualized Education Plan); social history; other evaluations/reports including occupational therapy, physical therapy, speech/language, hearing, vision, etc.; counseling records; 504 Plan; birth certificate; and any other information you feel may be pertinent regarding the following student:

_____ _____
Student's Name Date of Birth

Previous School District: _____

_____

_____

Send General Education records to:

Johnstown School District
c/o Cathy Ellis
1 Sir Bills Circle
Johnstown, New York 12095
Email: cellis@johnstownschools.org
Phone: (518) 762-4611 Ext 3113
Fax: (518) 762-3127

Send Special Education records to:

Johnstown School District
c/o Sue Hansen
1 Sir Bills Circle
Johnstown, New York 12095
Email: shansen@johnstownschools.org
Phone: (518) 736-1708
Fax: (518) 762-6027

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Student

_____
ADDRESS OF PARENT/GUARDIAN

Revised November 2017

GREATER JOHNSTOWN SCHOOL DISTRICT

Administration Center
1 Sir Bills Circle - Suite 101, Johnstown, NY 12095
Phone 518-762-4611
Fax 518-762-3127

SCHOOL ENTRANCE HEALTH HISTORY

Dear Parents/Guardians:

Please complete this questionnaire to the best of your ability and return it to the Health Office of your child's school. This information is for the school medical record kept for each child and is of great help to the school nurse and doctor in understanding and helping to safeguard your child's health. Thank you very much.

SCHOOL _____ **Grade** _____

CHILD'S NAME _____ **Nickname** _____

Birthdate _____ **Place of Birth** _____ **Sex** ____

Father's Name _____ **Place of Employment** _____
Phone _____

Mother's Name _____ **Place of Employment** _____
Phone _____

Home Address _____ **Phone** _____

Name of Doctor _____ **Address** _____

Name of Dentist _____ **Address** _____

Other Children in Family: **Birthdates:**

_____ _____
_____ _____
_____ _____
_____ _____

1. **Is your child currently being treated for an illness or ongoing condition?** _____
   If yes, please describe _____
   _____
   _____

2. **Is your child currently taking any medication?** _____
   If yes, what medication? _____
   Why? _____

3. **Do you consider your child's health to be: Good _____ Fair _____ Poor _____**

4. **Can your child participate in all school activities? _____**

5. **Does your child have any allergies (Foods, animals, medicines, bee stings, dust,**
   pollen, other) _____

   If he/she is allergic to bee stings, what actions do you want school personnel to take? _____

6. **Please check if your child has had any problems with:**

Asthma	**( )**	**Persistent cough or wheeze**	**( )**
Eczema	**( )**	**Tiring Easily**	**( )**
Frequent headaches	**( )**	**Stomach aches or vomiting**	**( )**
Dizziness or fainting spells	**( )**	**Bowel movements**	**( )**
Convulsions and/or Epilepsy	**( )**	**Hernia**	**( )**
More than 3-4 colds per year	**( )**	**Kidney/urinary problems**	**( )**
Tonsils or adenoids	**( )**	**Painful joints**	**( )**
Strep throat	**( )**	**Feet or walking**	**( )**
Frequent nosebleeds	**( )**	**Bedwetting**	**( )**
Anemia	**( )**	**Frequent temper tantrums**	**( )**
Heart problems	**( )**	**Rapid changes of mood**	**( )**
Diabetes	**( )**	**Eating problems**	**( )**

   If so, is the condition under the care or observation of a doctor?
   _____
   If YES, a statement from your physician is required.

7. **Has your child had any:**

Serious injuries	**_____**	**Describe**	**_____**
Serious illnesses	**_____**	**Describe**	**_____**
Accidents	**_____**	**Describe**	**_____**
Operations	**_____**	**Describe**	**_____**

8. **Has your child had any of the following diseases?**
   Measles _____ Chicken Pox _____ Rheumatic Fever _____

   German Measles _____ Mumps _____ Pneumonia _____ Scarlet Fever _____

9. **When did your child last have a complete physical examination? _____**

10. **Does your child have any eye problems? (difficulty seeing, crosses eyes, frequently reddened or watery eyes)**

_____

11. **Does your child wear glasses? _____**

12. **Does your child have any ear or hearing problems? (frequent earaches, draining from ears, difficulty hearing)**

_____

13. **Does your child wear a hearing aid? _____**

14. Has your child worn braces or corrective shoes? _____ Are they still being worn?

_____

15. Does your child have any speech problems (stuttering, difficult to understand, delayed speech development)

_____

16. Is a language other than English spoken at home? _____

17. Will your child require any special health care in school? _____
If yes, please describe: _____

18. Do you have any concerns about your child's general health, behavior, or emotional well-being of which the school should be aware?
_____

19. Was this a normal, full-term pregnancy? _____

20. At what age did your child walk? _____ Talk? _____ Toilet train? _____

21. How did your child develop compared to other children the same age?
Faster _____ Slower _____ About the same _____

22. Please check if your child had any of the following experiences which might influence his social or physical development:

Frequent changes in residence	**( )**
Death in family	**( )**
Fires	**( )**
Accidents/Injuries	**( )**
Other	**( )**

23. Please check if you expect that your child may have any of the following problems when he/she begins school:

Leaving home for the first time	**( )**
Getting along with a new adult	**( )**
Dressing, eating, toileting by himself	**( )**
Getting along with other children	**( )**

24. Family History: Please check any that apply to your immediate family and explain the persons relationship to your child (mother, father, sister, aunt, grandmother, etc.)

Physical disability (describe) _____
Epilepsy _____
Diabetes _____
Intellectual and Developmental Disabilities _____
Depression _____
Vision Problems _____
Hearing Problems
_____
Thyroid Problems _____
Scoliosis/back problems _____

Convulsions _____
Heart Problems _____
Other _____

25. Are there other concerns regarding your child that you feel the school should be aware of: _____

Parent/Guardian Signature _____ Date _____

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:		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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: